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The Japan Psychoanalytic Society
4 Yotsuya 3- Chome, Shinjyuku-Ku, Tokyo 160-0004, JAPAN
E-mail address: tokyo@jpas.jp
Fax: +81 33 3263 8693
Homepage: www.jpas.jp/ja/ (Japanese). www.jpas.jp/en/ (English)

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Editorial

I have started to work as the Editor-in-Chief of the Journal of the Japan Psychoanalytic Society from June 2022; following in Dr. Kenichro Okano's footsteps. This is my second term as during my first term I worked in charge of vol. 1.

In this volume 5, the readers will be able to learn about the kinds of psychoanalysis rooted in traditional Japanese culture through both an excellent paper by Dr. Jhuma Basak, a member and training analyst of the Indian Psychoanalytical Society, and also from a beautiful paper by Dr. Osamu Kitayama which is a matrix of Dr. Basak's paper.

I express my sincere gratitude to Dr. Basak for her permission to publish her important paper.

There is another excellent project in this volume. It consists of highly significant papers and discussions by young psychoanalytic students whose psychoanalytic trainings have contributed to the clinical practice and the formation of the identity of being a psychiatrist. I expect you will enjoy reading it.

The Covid-19 pandemic, which had incapacitated us for so long and demanded us to have the negative capability, has been diminished. These last few years, it had burdened all human beings with the feeling of an impending catastrophe, and also for those of us working in psychoanalysis. Because of this, I hope we do not forget it so easily and are able to reflect on it, contemplate it, and learn from it.

We plan to publish the next issue as an AMAE special edition.

June, 2023
Editor's- in-Chief, Kunihiro Matsuki

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Invited Paper and Discussions
Introduction

Introduction of Dr. Jhuma Basak

Takashi Okudera

Clinic Okudera

Today, I'm so honored and privileged to introduce Dr Jhuma Basak, as we know each other for a long time, as well as her familiarity with the JPS, since she had studied in and graduated from the Kyushu University Doctoral Course. According to customary, I would talk about Dr Basak's bio.

> Jhuma Basak is a Training & Supervising Psychoanalyst of the Indian Psychoanalytical Society. She completed her Ph.D in Psychology from the Kyushu University, Fukuoka, Japan.
>
> Basak pursued her interest in psychoanalysis with specific emphasis in culture, women, & gender. She has international publications in journals & books translated into different languages like Japanese, Italian, French & so on, along with papers presented at various international IPA Congresses over the last 20yrs. She is the co-editor of the book, Psychoanalytic & Socio-Cultural Perspectives on Women in India, Pub. Taylor & Francis Group. Her edited book on Sudhir Kakar, Sculpting Psychoanalysis in India, from the Oxford University Press is in press.
>
> Basak has been the past Co-Chair of Asia COWAP-IPA (committee on women & psychoanalysis, 2017-2021), and organized the first 2-COWAP international conferences in Kolkata, India, in 2018 & 2019. Currently she is the Co-Chair, of Allied Centres of the Independent New Groups (ING of IPA), and member at the IPSO & IPA Relations Committee (IIRC). In May 2022 Basak was invited to present at the Washington Baltimore Centre for Psychoanalysis on 'Psychoanalysis & Poverty'. She has been invited to be the Keynote Speaker from the coming 4th region of IPA for the 53rd IPA Congress to be held in Cartagena 2023.

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Takashi Okudera
Clinic Okudera
4F Kyodo KHS Building, 2-18-1 Kyodo, Setagaya-ku, Tokyo
e-mail: t_okudera@nifty.com

Basak offers lectures in Psychoanalysis and Psychology in different universities of India, and conducts workshops with NGOs and at other social, community platforms.

She has her own private clinical practice in Kolkata, and is associated with a private hospital in Kolkata. She is the Founder of Mira Centre for Innovation (in memory of her mother) working on mental health, arts, & education in the community.

In addition, I would like to quote the abstract of Professor Kitayama's paper in the referral.

Becoming Drawn into a Primal Scene
Osamu Kitayama

In this paper, I want to focus on the primal scene, meaning a child's witnessing his or her parents' sexual activities: an issue that is known to be taboo. In the myth that describes the birth of Japan, the death of the maternal deity which the paternal deity witnessed on breaking the 'Prohibition of Don't Look,' was due to their sexual intercourse. Not a few Japanese shunga prints depict children as observers and participants in the parents' sexual acts. This is related to what Japanese scholars studying Ajase-Complex refers to as the culture of parents sleeping with their child in between, like the Chinese character for 'river,' (川). In this threesome situation, by having the mother doubling her body, or her role, as both a wife and a mother, the child, who has been elevated to the same position as the father/mother by sleeping together with him/her and coexisting with him/her, risks becoming drawn into the parents' sexual activities. Taking into account the pathogenicity of the primal scene, we must discuss possibilities of traumatic involvements that were suggested in Freud's case reports such as "Wolf Man." We can expect to see a situation in which phantasy and reality become mixed together, causing two types of pathological involvements. In the latter half of my report, based on cultural searches, I would like to limit my clinical materials in this presentation to eyewitness testimonies, of "the murder of a mother by the father" in both a boy's and a girl's case. Talking overtly about a primal scene, the patients describe their helplessly witnessing the murder of the mother by the father. Based on the cultural studies and clinical examples, I stress the likelihood of, and the pathology of, people in our culture frequently experiencing participation-type primal scenes, of a child sleeping together with his or her parents.

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Invited Paper and Discussions
Invited Paper (Interdisciplinary Studies)

[Original Paper]

The enthrallment in the primal-scene

Jhuma Basak

Indian Psychoanalytical Society

> *"It is a joy to be hidden but disaster not to be found"*
>
> Donald Winnicott

Introduction

Allow me to begin with my due acknowledgement of all my Japanese colleagues and their works over decades in the field of psychoanalysis in Japan. I have tried to learn from them, and continue to learn with my humble capacity, about psychoanalysis in Japan and its unique way of reading human mental mechanisms—making it a distinct analytic pathway alongside a universal psychoanalytic paradigm.

Let us begin with the root to the Unconscious, i.e language in Japan – the ambiguity and suggestiveness in Japanese language makes it imperative to understand its cultural nuances in order to comprehend the complex elucidation inherent in their psychoanalytic theories, like the Ajase Complex (by Heisaku Kosawa, 1932), and the Prohibition of Don't Look (by Osamu Kitayama). Both Kosawa and Kitayama exemplified the symbolic ingrained in Japanese language with mythological references from Japan in elaboration to their clinical analysis. The unfolding processes in both these conceptual developments implies a hidden injunction of time during which period the psychic maturational transformations (of the reader/beholder) would enable the capacity required to contain witnessing a catastrophic moment of breaking a prohibition along with the breakdown of one's illusion of an ideal love object. With this perspective in mind, a re-look at both these analytical concepts of Japan may give us an opportunity to further examine the many layered intercommunications innate in them. Subsequently it may add another dimension to the theories making it rich and compound for our present analytic discourse. Osamu Kitayama's present paper, 'Becoming drawn into a primal scene' (2022) is an exemplification of one such unfolding

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Jhuma Basak PhD.
Indian Psychoanalytical Society
basak.jhuma@gmail.com

process that started its journey of unraveling with his work on 'The Wounded Care-taker' (1991), taking us from the dyadic pre-oedipal prohibitions to the tripartite oedipal torrents built-in within the Prohibition (as discussed in the primal-scene paper of 2022).

A Turbulent Emotional Background

A conflictual, piercing, emotional entanglement maybe discovered in the Ajase story where the birth of Ajase itself was rooted on maternal acrimony and betrayal of Idaike, who herself was struck with dreadful anxiety fearing the loss of her husband's love. Idaike's rancor was based on her grievous lament of losing the love of her husband which perhaps found a displaced venting on her son. Her bitterness instilled the 'complex' in the Ajase story with counter provocation of matricide and prenatal rancor. But over time, with the maturational process, Idaike overcame her own resentful limitations and looked after her sick son to heal him with bountiful love/*amae*, endowing the seed for reparative guilt (as in the Kleinian sense) in the mother-son object relationship. Thus, Ajase could initiate the course of reparative guilt within him towards his mother, perhaps internalizing a cyclic process of maternal forgiveness that he saw his mother act upon. Subsequently being contended with *amae*, having gained his primary narcissism Ajase's latent ground for reparative guilt was prepared to carry forward the quality of generosity. Over time both Ajase and Idaike moved from an infantile state of dependency/*amae* to a matured quality of amae of inter-dependence within the symbiotic relationship—perhaps a psychic move from the 'paranoid-schizoid position' to a 'depressive position' (Klein). According to Kitayama's inference, the state of *amae* is both transitory and transitional, locating it midway between 'one-ness' and 'separate-ness'—that which is interpolated between the enmeshed ego of the mother-child dyad and the later progression towards the separation-individuation process. The inherent dynamic quality in *amae* gives it the probability of a transitional element that can travel from individual to individual, generation to generation, implying the significance of time and its intrinsic transformational potential effecting society and community over time (Okano, 2019).

It maybe noticed in the above mythical references a direct connection of parental coitus with sexuality, birth, and death, all inter-connected with each other—making it a potent ground for intense emotional embroilment. However, this inner crescendo is meant to be private in these mythologies as much as in Japanese life and culture. Nishizono explained this inner world as *uchi* from *soto* (external world), maintaining equity between silence and articulation, an equivalence of Winnicott's 'true self' and 'false self'. The 'shameful self' maybe hidden from public but not necessarily from one's own self. Language is the symbolic route to the Unconscious, and thus the query into Japanese language – its articulation, symbolic references, silences—has acted as a primary pathway to understanding its people, its psyche, and culture. The site of silence in the Japanese language is very significant, i.e. between what is uttered and what is suggested, making metaphoric qualities for dynamic interpretations embedded within the language. Simultaneously, it equally adds the enquiry of ambiguity in it. In this sense the personal, private, dyadic pre-oedipal object-relationship with the mother maybe robust with fierce emotional coil, while the 'impersonal' code of social conduct in daily-life in Japan (a triadic oedipal manifestation)

may imply this multi-layered complex suggestiveness.

According to the *Kojiki* myth of the Izanami-Izanaki legend, the birth of Japan unravels Izanami's process of giving birth to different deities (that is the many islands of Japan), and while giving birth to the fire deity it left her with burnt genitals. The paternal deity, Izanaki, witnessed the death of the maternal deity, Izanami, by breaking the "Prohibition of Don't Look'. In further elaboration of the story of the Crane Wife (in 'Becoming Drawn into a Primal Scene') that exemplifies the theme of the Prohibition of Don't Look, Kitayama mentioned that the act of piercing with an arrow on the crane's body symbolizes a sexual act which after being witnessed and exposed brings an end to the life of the crane-wife. As Kitayama mentioned that it brings "death while engaging in a sexual act" (Kitayama, p.1) for the maternal object. By this, it is suggesting a simultaneous celebration of the birth of life with sexuality, and a coexisting mourning of death (of the maternal deity/mother/wife) in this singular act. Thus, it may appear that sexuality in these mythical expositions are burdened with ambivalence and an intense entanglement of adult passionate sex, infantile child birth, along with unsightly repulsive death—all echoing a powerful psychic trilateral entrapment comprising sex, birth, and death. Subsequently echoing in the backdrop is a symbolic and compelling triadic bonding between the mother-child, and the father. It is very difficult to distinguish clear boundaries in these interrelations—ambivalence and ambiguity plays a vital role in intermingling sexuality with motherhood, or infantilism with parenthood, or sexuality with infancy, as it may often get voiced in clinical contexts as well.

Triadic Sleeping Together in Infancy—A Reflection

The essence of the compounded trilateral involvement of the mother-child and father finds rumination in Japanese culture of child rearing practices. Okonogi's analogy of the child sleeping in between the parents as the Chinese character for river, and a 'state of threesome in infancy' with the mother-child, and father in bed together adds to the triadic narrative. Kitayama further refers to *shunga* or erotic prints of Japan to elucidate the role of the ternary in the child's development and its sexuality. As is well established by now, the dyadic bonding between the mother and the child (specifically the son) is very unique in the eastern context. The intense play of *amae* in the mother-child object relationship creates the shield for less probability of oedipal rivalry between the father and the child (son). Thus, when the father joins the mother in bed, i.e. the site of their unique 'tryst'—an intimate rendezvous between lovers' union—the mother-child duo stands inseparable. Perhaps the father experiences a sense of betrayal by the wife in his tryst with her, unless he shows an evolved cultivation of *amae* to yield to the mother-child duo. That way the pre-oedipal bonding of *amae* in the mother-child duo stays free from the later oedipal sexual struggle. The undercurrent of this silent triadic troth, stimulated by the 'state of threesome in infancy', perhaps creates the possible bedrock of filial pledge, a sense of almost paralyzing commitment towards the family. It maybe observed to be a foundational characteristic in family structures of both Japan and India (perhaps the east at large). There is a coexistence of the three together, implying a subtle non-exclusivity in the couple formation that is usually the practice in other western societies. This coexistence

is possible because it incorporates the 'this and that' in such eastern societies, and not the dichotomy of 'this or that'. This maybe the root to understanding the significance of intense community attachment and filial vow in some eastern societies, as in the Indian context. In the Indian child rearing practice, it may still often be noticed that the child may experience more than a single mother phenomena where the child grows up with the grandmother's breast/lap or aunt's/*aya*-s (nanny's) breast/lap in addition to the mother's, all who are readily available within the household to take care of the child when the mother of the family may be taken up with other household chores. The later development of a complex, multiple-attachment schema maybe a foundational phenomenon in such circumstances that may further call for analytical investigation upon its adult love and sexuality, though not necessarily suggesting a 'pathological' frame of reference for corrective measures.

The practice of triadic sleeping together of the mother-child, and father as noticed in the Indian context as well corresponds to the unique cultural practice of the supremely significant status of the mother-child bonding as described in the Japanese tradition. It also correlates to the socio-economic plight in India—the sheer lack of physical space to have different rooms for different members of the family is often not a choice. The triadic sleeping together is a most 'natural' rearing custom for most Indian families. The central positioning of the child in between its parents in bed—also signifying the central positioning of the (male) child in the family. Simultaneously, the ambivalence of the child is rooted in this very middle position of the triadic sleeping together, and "I believe the bedroom circumstances are behind this tendency of anger being directed at the mother but not towards the father" says Kitayama (p.3). That is so because for the child it tends to think that the betrayal was made by his mother who by choosing the father over her child in their trilateral struggle at the very site of their triadic sleeping together has forsaken the child. Perhaps it conveys the mother's sense of duality in love who herself has been left with no ambit for the couple's exclusive intimacy whatsoever. This way the mother appears to be the common object of enmity for both the father and the son—unless the quality of *amae* showers upon with forgivable maturational implications for both the father and son. The child feels both secured and torn apart, all at the same time, in this heightened stimulation. The clinical space in the Indian context may at times witness such painful and fierce internal vacillation in long and deep analytical work with patients.

'Participation-type' primal scene

Drawing directly from the practice of triadic sleeping together in bed, Kitayama distinguishes the child's role in this trilateral constellation as 'participation-type' primal scene from 'witness-type' primal scene. In participation-type primal scene the child *actively* joins the parents in their sexual encounter with each other. Here, *actively* for the child does not necessarily imply its capacity to exercise *self-agency* in choosing, but drawn by the parents' enticing ring of tryst in bed its consequent *active reaction* at the very site itself that makes it participate in the triadic act of intimacy. In that sense, conceptually it is a 'participation-type' (active) primal scene, distinct from 'witness-type' (passive) primal scene. Subsequently, the child's psycho-somatic stimulation along with its provocation for sadistic/masochistic propensity depending on its vast identification with active or receptive

aspects of parental masculine/feminine qualities, or voyeuristic trepidation, may often be an early onset of a possible pathogenesis. It may at times lead to even catastrophic developments in the later years of the child (as will unfold in the subsequent clinical reference here). However, this does not entail 'pathologizing' such an aetiology that occurs under diverse practices of different socio-economic cultures. Rather it is staying committed to an ethical reading of divergent rearing habits and approaching the triadic tryst in the oedipal ordinance as an allegorical field of different symbols and metaphors according to diverse cultures that resonate later in complex adult sexuality. Often it may appear that the dominant intrusive Eurocentric critic of non-western cultures brings about an unconscious aspiration in our subjugated subjectivities the need to prove ourselves 'clean and pure' from our inherited indigenous allusions. In *Group Psychology and the Analysis of the Ego*, 1921, Freud formulated that the modern individual subjectivity evolved out of disorderly communities, thereby implying a possible subtle hierarchical psychic configuration that distinguishes the new, emerging ego from the unruly reckless herd. But is the 'primal' the mark of 'primitivity', implying racial ethnicity and the individual ego the mark of civilization of the 'white west' (Celia Brickman, 2018)? Perhaps both the primal and the individual hold a simultaneous coexistence in such contexts. Perhaps it is time for us to liberate ourselves from such 'prejudiced scientific axioms' and learn with a free mind from our galaxy of diversity in human cultures and its numerous forms of psychic structures.

Clinical vignettes

Case - 1

Dia was a 35yr old working woman, taught language and literature in a high school. She was married for 8yrs with a son of 6yrs. She came for consultation with her growing anxiety, something that she complained had troubled her since childhood. Increasingly she found it difficult to speak, as her voice would often shake while taking classes in her school. That frustrated her and angered her, made it difficult for her to take her classes with ease. Thus, she tried to speak very softly and as little as possible so that she could keep control over her shaking voice—something that found expression even in the sessions. It appeared almost like a hysterical quiver underlining her voice, but one could equally feel the suppressed voice in her that was waiting to pour out—as if something was eager to burst forth. She was in a constant state of jitters and nervousness. Dia wished to go for analytic treatment with 2-sessions a week.

Dia was sharp enough to know what was pounding inside her for which she was suffering for long. She wanted to talk about it since it was something that she couldn't talk to anyone about, something that she was extremely guilty about and felt terribly disturbed with the whole thing. She feared that if she could not speak about it with someone whom she believed would be able to guide her properly on it then not only her own state of mind and her conjugal relationship would be at stake (because she did not enjoy having sex with her husband, nor did she groan with orgasm ever—like she remembered her parents!), but also it may have its impact on her son due to her own suppressed desires around him, and thus she would lose all bearings of life with her loved ones. This made it possible for us to approach the subject quite immediately into our analytic working together.

D: "I cannot deal with this anymore. It has ruined my life. I am always angry, guilty, nervous—I don't know what I feel anymore." She was evidently agitated.

Dia started her narrative from her early days when she used to sleep with her parents in their bed, in between them. She felt her anxiety started from that time itself. She disclosed how since childhood she used to enjoy watching, listening, to her parents having sex (needless to say that at that time she did not understand it was 'sex'). They thought that she were asleep while she would only pretend to be so. She remembered her heart throbbing when her parents would start their 'physical fights' at night—in her mind the parental intimacy/sex appeared like a physical fight. Though she felt anxious but she even looked forward to those 'physical fights'—it was like a ' prohibited private show' of some kind performed at night. She had an internal clear division of the 'morning fights' from the 'night fights' of her parents. The morning fights were only verbal fights with them screaming at each other in the open, in full light. According to her at times the 'night fights' would also have some whispering verbal fights like the 'morning fights' – which became her favourite ones because those specific fights held a conviction for her. Once her parents had a combined physical and verbal fight at night (implying the orgasmic moment) she knew that soon the fights would be over, they would be still, the night-show had come to an end, and she would eventually lie still like them, falling asleep. And in this manner she would be a co-participant in the parental sexual encounters.

Dia recalled having slept with her parents in their bed till she was about 6years old when the birth of her baby-brother in the family displaced her middle position in the bed/ family, and she was shifted to the divan in the sitting room. She was not only angry with her baby-brother for whom she was thrown out of her parents' bed, but was even more so with her mother who happily, lovingly, kept that "ugly baby" next to her, gave it her breast, and just forgot all about her daughter. How could her mother forget her just like that, so easily? She was there next to her mother's side for all those years, much before that "ugly baby" arrived, and her mother just threw her out of her bed just like that! And like this Dia imagined a sense of betrayal and abandonment by her mother. She would stay awake at night on her divan in the other room, waiting most desperately to hear her parents' 'physical fights'—that way she would feel somewhat symbolically bodily close to her mother, reassured and secured in her psychic middle position of infancy… I wonder if her later quivering in her voice found its seed in the night sounds that she yearned to hear from her parents' joint vocal spells which reassured her own secured middle position. Thus, unknowingly she inherited that tremor within her (like the throbbing bodies of her parents maybe), and did not want that faint vibration in her to leave her. Was she caught, trapped, in that whispering/groaning from her past-reality merged with her fantasy that she unconsciously carried it within her even when she was speaking in general. On one hand the 'symptom' itself resonated a shaking, quivering quality while its presence seemed to have acquired her imagined security.

By the time Dia was in her teens, she discovered her strong attraction for watching movies. She loved the late night movies in TV when she would sneakily go to the sitting room and watch them in the dark. In sessions she drew her own association of how this may have been a symbolic representation of her watching the 'night-shows' in her parents' bedroom. But at times she would be desperately drawn to her parents' bedroom to secretly

watch her 'original night-shows'. This always left her feeling terribly guilty afterwards, but equally left her feeling excited and anxious. With such severe emotional unrest she at times felt very tired during the days when she would wait for her mother's gentle physical touch and presence. Her mother would come to her and quietly just touch her forehead, sit by her and try to make her laugh. She loved those tender moments, found them so peaceful. But the apprehensions of the nights scared her, excited her, all at the same time—her ambivalent oscillation between yearning for maternal love and caring touch, and her curiosity for sexual stimulation found words of expression in the gradual sessions.

What disturbed Dia the most was her obsessive imageries of parental sex that dominated her till date, even when she was involved with her husband in physical intimacy. She wondered if those images excited her to enjoy having sex with her husband, did she try to imitate those images in her own act of making love with her husband? All of this left her deeply upset, consequently she could not enjoy having sex with her husband. What frightened her the most, and that's where she clearly articulated her immediate need for analytic intervention, was her growing visual of seeing herself as a child watching her parents in bed and often, unknowingly, having her son exchange position with that little girl in her mental images. She was terribly disturbed with her own imaginations, and wanted to stop them somehow. She felt extremely guilty. She sounded like a desperate child who was seeking help to be saved by her mother/analyst—to free her from the seductive maternal sexual web. The internalization of the desired maternal in transference helped Dia to imagine a loving maternal object relationship, free from its undue sexualized inundation. That reassurance and anchoring gave her the emotional strength to look deep into herself—she could not forgive herself for the horrible, disgusting, fantasy of hers of wanting to entice her son. She was further puzzled thinking if her mother also wanted the same with her, did she learn this from her mother. This gave opportunity for our analytic work to introspect the nuances of Dia's loving quality for her son. Also, it further opened up avenues for us to perceive, at least to some extent, her mother beyond the socially defined maternal role. The deeper her own contempt and aggression got worked through in the sessions the clearer she could see the extent of her own imagined sense of maternal betrayal and abandonment that she accused her mother of. And in this process, the hysterical quiver in Dia's voice gradually gave way to a clearer and confident voice—she started enjoying taking her classes once again. Her intimacy with her husband was more anxiety-free, and she was less dependent for stimulation from her inner imageries of parental intimacy. She was engaged in creating her own sexual narratives of intimacy with her husband, an intimate embodiment of her self-agency.

Case -2

Ajit was brought for consultation by his father when he was 16yrs old. He was alarmed with Ajit's increasing physical demands over his mother in the past one year. The mother looked like a quiet lady, a little demure perhaps in nature, smaller in size to her husband who had a large stomach with a loud voice. Ajit had a rough and unkempt look, perhaps echoing his youthful defiance as well as indirectly challenging our acceptance of his inner "repulsive self" as his father referred him to be. His apparent aggressive attributes were threatening towards his parents. The mother reported that from childhood Ajit was

aggressive and demanding. A way of calming him down was to hold him close to the mother's body. This became a natural pattern over time, and to fall asleep he would often take his mother's nipple in his mouth, like most children, and sleep peacefully. As Ajit was growing up, this habit got substituted by having his hand over his mother's naked breast. Initially both the parents did not mind this, saw this as a child's harmless demand of playing with the mother's breast to sleep. The father slept in the same bed, next to the son while Ajit slept in between his parents.

However, by the time Ajit was about 12yrs old the parents tried to change this habit of Ajit's since he was becoming somewhat adamant about his mother. They tried to have him sleep in another room with his grandparents. But even in the middle of the nights Ajit would keep coming back to his parents' room to sleep next to his mother with his hand over her naked breast. If the mother resisted this Ajit would become very agitated till his father would intervene by forcing the mother to allow Ajit to do what he wanted so that he could sleep through the night and be fresh for his office the next morning. Ajit enjoyed this powerful position where he had his father on his side to make his mother succumb to his demands. One would notice Ajit's early expressions of his manipulative, sadistic ways. Over time the father started feeling a little uneasy of his son when Ajit started making further demands of his mother, almost persecuting her, and would not listen to any stopping of his persistence. It appeared that Ajit's sense of reality was merged with his desire in attempting to be like his father in his fantasy in acting out the 'nightly actions' claiming his mother's body. His fierce stimulation and possible identification with the masculine/the father (-in-bed in particular) from childhood may have invalidated his capacity to experience object relationships in other empathic receptive nuances, thereby losing perspective to distinguish it with reality boundaries and reality roles. Equally perhaps the seductive feminine receptive in the mother (who was by character a quiet natured woman) excited his dominating fantasy of possessing the maternal object to claim his infant feeble self with an omnipotent armour of virility. Thus, over time the making of his authentic subjectivity became a fraught process.

In sessions he would often make it clear how he was a good man, unlike what his father had been projecting him to be. At least he never wanted to physically hurt his mother, contrary to his father who would often hit his mother after coming back home drunk at night followed by his command over his mother in bed. And then his mother would take Ajit in her arms and go off to bed together with her, holding Ajit tight against her chest, sobbing quietly. He remembered how at such times his mother would take his small soft hand and place it on her breast before they both fell asleep. Perhaps for the mother the gentle, benign touch of her son's innocent hand reassured her of the existence of love and care, which she probably missed from her husband. For Ajit this gesture became a complex symbol of him protecting his mother from the father, being gentle and caring with his mother when she would be crying, along with his erotic incitement being close to his mother's body. Ajit's being drawn into his parental vacillating intimacy and their ugly fights left him emotionally baffled, which further affected his cognitive inference of reality.

Thus, it was difficult for Ajit to understand why suddenly his mother too objected to his growing physical closeness towards her. He still used to love her the same way as he used to when he was much younger, lying next to her comforting her with his gentle hand

stroking her breast. He did not realize his reality shift from those soft stroking hand to his commanding body/self over his mother. While saying this it appeared that he was almost drowsy and would doze off to sleep as he did in his earlier days lying next to his mother with his hand on her breast. The difference in this context was that in the analytic situation it was next to me that he was lying down on the couch, and it probably invited for an analytic intervention into his unconscious—

> "maybe you want to fall asleep here too, with me, like you used to fall asleep with your mother"
> A: yes, it feels so gentle and quiet…(*implying without the sexual provocations?*)
> "just like how you wanted your mother to feel the gentle caring love of your father through you stroking her breast. You want to love and protect your mother but no one is understanding your inner motive".
> A: "even my mother doesn't understand that?"
> "perhaps you could explore other ways of loving and caring for her, other than the ways that you learnt from your father-in-bed. Maybe that will help your mother to understand you better".

In later sessions Ajit further explored his feelings of disgust about his mother especially when he was close to her. Initially it was disturbing for him to accept this because he actually loved his mother so much, he could not understand why he felt like that. It assisted the analytic situation to be able to dive into Ajit's whirlpool of imageries of parental coitus that was both a reality provocation as well as a fantasy stimulation for him. It acted as a point of fixation for him invoking ambivalence. He could see how he was dragged into it, enthralled by it, he felt excited by it but equally disgusted and aghast by it. His point of crushing ambivalence & helplessness was getting an opportunity of being dealt with in the sessions. Gradually he could come to terms with the fact that it was possible for his parents to be aggressive and fighting with each other as well as to love each other enough to continue living together for so many decades. Just as much as his own initial resistance towards me could also turn into an affable, affectionate quality. Equally, with time, he could begin to see his own coexistence of thoughts, feelings towards his mother whom he could love and respect in totality but had his bitter feelings against her in context to another time and situation when she failed to provide him with maternal protection. In terms of the transference situation the consistency of the object/analyst's benign self and the feeling of acceptance, as experienced through the analytic process, helped Ajit to internalize a modified generous analytic reverie (Ogden, 1994). Subsequently it helped him to draw his experiences into the intersubjectivity of the analytic pair, which subsequently nurtured him to begin cultivating a self-reliant subjectivity from his parental tryst.

Conclusion

The essence of the playful infantile merged with sexuality maybe found in the many loving names given to the genitals in everyday language in the cultural context of Bengal (eastern India), for example 'shona' (meaning gold in Bengali) for vagina, or 'pakhi'

(meaning bird in Bengali) for penis. Such locutions may bring about amiable, mischievous associations to the patients in the clinical space which may further help in mitigating the violent tryst of parental seduction of being drawn into the 'state of threesome'—perhaps accompanied by a salient somatic giddiness echoing its intense intoxicated whirling state—and proceed with its articulation. Thereby, attempting to open up the compelling orbit of a reality-merged-fantasy in its enthralling 'state of threesome in infancy' to another being (the analyst), freeing its subjectivity from the gripping parental pledge. To be able to go beyond the external and internal prohibitions revolving around the 'state of threesome in infancy' in both the cultural and clinical contexts calls for an internal mature readiness as well as a ripe-enough time for the analysand/reader in order to negotiate its many cultural/clinical complexities and resistances. To be able to bear the symbolic lack/death of the maternal in the 'state of threesome in infancy' the child/growing-adult needs a certain "externality and objectivity from us analysts" (Kitayama, p.9) who may facilitate the containing process. The analyst's understanding of the complex and culturally shared phenomenon of the 'state of threesome in infancy' eventually creates the basis for the 'empathic third' in the clinical duo. The dialectical interplay of the two subjectivities in the clinical duo builds the abstract 'empathic third' that further assists in the internalization of a mutated reverie for transformational developments in the ego construction. The mystery and joy of being hidden needs to be very gradually unravelled over a long period of time. As Okano says quoting Kitayama, a taboo to be broken in time (2019). And that may eventually prepare the evolving subjectivity to go beyond the Prohibition of Don't Look and "uncover the ugliness and weakness in real human beings" (Okano, 2019) to claim its liberated, disenthralled position (i.e. not in opposition or exclusion to its fundamental enthrallment, but as an extended inclusive parameter of certain socio-cultural practices in society that may prompt desire with due agency in human entity).

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Invited Paper and Discussions
Discussion

Discussion of Dr. Basak's presentation

Naoe Okamura

The Institute of Japan Psychoanalytic Society, Hatsuishi Hospital,
Private Practice of psychoanalytic psychotherapy

First, I thank the Institute of Japan Psychoanalytic Society for this precious opportunity for discussion. The two case descriptions presented by Dr. Basak are like an inspiring movie. While my mind is still captivated, first, I would like to share my thoughts about the presentation as a whole, and then ask some questions about the cases.

When I read Dr. Basak's paper, the first thing that came to mind was that I was raised with bed-sharing (actually futon-sharing) and co-sleeping with my family, and I raised my child the same way. As Dr. Basak writes, it was "most natural." In reality, there was no other room for the children, and there was a fear of earthquakes. Culture is thus inseparable from landscape and climate and shapes the nature of the body and mind.

In modern Western culture, parents' bedrooms are separated from children's bedrooms. The bedroom doors remain closed and opening them is forbidden. Freud reiterates in 'Totem and Taboo' that what is forbidden causes strong ambivalence. If someone thinks something has magical power, that person prohibits it. The way it is prohibited affects the imagination and meaning created there. A thing is not necessarily strongly prohibited because it has strong power; however, because it is strongly prohibited, it becomes more magical in some aspects. I am trying to say that parental sexual activity may have been enhanced in its good or bad magical power by being closed off in another room, out of sight. Sexual excitement can cause trauma and impingement in children. However, in many Asian countries, where it is common to share a bedroom or bed with parents, the "don't look" prohibition is loose and lax. Thus, rather than being frozen by what they witness, as Dia described to her analyst, the infant is excited, evident in his/her movements and gaze. The child's experience of the scene of the parents' sexual bonding could contain a wider variety of core patterns and effects in human relationships (such as identification, jealousy, envy, love, hate, and immediate reversal of those relationships). Dr. Basak's presentation made me aware of the possibility of experiencing less tight/frozen but more

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Naoe Okamura MD, PhD
The Institute of Japan Psychoanalytic Society, Hatsuishi Hospital, Private Practice of psychoanalytic psychotherapy
SC Building 6th Floor, 3-4 Yotsuya , Shinjuku-ku, Tokyo 160-0004, Japan
e-mail: okmnaoe@mac.com

in-motion and rich affectionate relationships in the field of parental sexual act.
Freud repeatedly states that the primal scene is neither imaginary nor real. Today, the term primal scene is often used as an innate and unconscious fantasy, or an abstract concept that is a prototype of a traumatic relationship. However, what Dr. Basak describes is a real bedside experience and memory. The triadic sleeping was depicted in the narrative as a real existing place where the patient, mother, and father can connect, sometimes across generations, and then reconnect with each other, and where the patients can store and recall their experiences. Considering that the bed is not only a place for sexual activity but also a place for sleeping, dreaming, and waking up, the site of triadic sleeping could be the significant primal environment for many Asian people that can be thought of and elaborated in many ways.

Conversely, triadic sleeping may be related to reality. Freud says that representation emerges when something is absent. When I think about the relationship between thinking ability and the absence of an object, being with the parents at night would have a significant effect. There may be differences in how fantasies are experienced and parents are renounced. This could lead to different thinking and usage of words. This is a major area worthy of study in culture and clinical practice.

From here on, I will comment on the clinical cases presented by Dr Basak.

The state of Dia's voice has several meanings. Dia's shaking voice is eloquently described as "like a hysterical quiver" while "waiting to pour out." At the beginning of the therapy, Dia's ability to experience pleasure and speak out loudly was projected onto (and arrested by) her mother. Dia's son was six years old, and Dia might have been unconsciously reliving her experiences at six years old. What she experienced with her brother's birth was losing the best place, the center of the parents, omnipotently identifying each parent, moving together, and some tense anxiety; however, she experienced security after the excitement of the coitus. In her teens (maybe when her brother turned six and she turned 12), she started feeling consciously drawn to peeking at the sexual act of her parents. Perhaps the guilt intensified the prohibition, and the intensified prohibition increased arousal and drowning strengthened. Unconsciously returning to this situation, this drowning limited Dia from present sexual pleasure and taught her class confidently. With the help of the analyst, Dia became more freely linked to another part of herself and experienced various emotions toward her mother, especially negative emotions, and freed herself from the arousing and horrifying sexual scene. This seems to have restored her power, and she allowed herself to experience sexual pleasure fully. She talked about wanting to experience orgasm and vocalized groaning loudly like her mother, where she separated her sexual drive or pleasure from her mother's and used her mother as her ideal image in a sexual relationship with splendid pleasure.

It seems to me that Dia's ego-need was not sufficiently fulfilled by her mother. Dia might experience her mother as stimulating and fascinating while ultimately neglecting her need, not only at night but in the daytime. This must have horrified Dia, who unconsciously identified the need to give her son the care and comfort she longed for. This could have triggered the symptoms that brought Dia to her therapist.

Now I want to ask Dr. Basak, who is the same gender as both Dia and her mother, how you experience a sense of enthrallment in the process of Dia's recovery?

Whereas Dia's story centers on her relationship with her mother, Ajit's story seems to center on his relationship with his father. Ajit's father brought Ajit to the analyst and told the analyst that Ajit was morally superior to him. Ajit's bed of triadic sleeping is a place of direct competition with his father over his mother. Ajit's small and quiet mother does not work to mitigate the rivalry between father and son, but intensifies it. It seems the mother herself is a frail being in need of a good object to turn to. She sobs on the bed that pits her husband against her child, which fails and causes sequential disaster. Ajit and his father have a projection of grudging from passive, vulnerable women by not being adequately protected.

Nevertheless, the transformation of Ajit's tiny little hand on his mother's breast, becoming more dependable than that of a man's hand, is photogenic. Meanwhile, the mother's breast must have changed from a firm, taut breast to a soft, wrinkled bulge. It is a scene that stays because it eloquently illustrates that there cannot be a clear boundary line in the mind to separate a child from a grown-up, mother from a woman, and man from a son.

My question regarding Ajit remains: How did he experience his mother? From the exchange with Dr. Basak and Ajit quoted in the presentation, Ajit was primarily in need of a mother who could comfort him. His aggression toward his mother led to fighting against his father because of his stern physical demands on his mother, becoming a ruthless omnipotent baby king ruler over both father and mother. It is significant that Ajit later felt disgusted about his physical closeness to his mother owing to the work with the analyst. Is it that he suddenly felt seduced by his mother's rejection, that is, the mother started seeing him as a grown-up man, before he recognized sexual impulse inside him towards mother? It seems possible that he experienced his mother's rejection as a sexualization of their year-long mutual ego-supporting bond. However, it is also possible that he started using his mother as an object for his sexual urge. I would like to know how Dr. Basak understood Ajit's dynamic family relationship. Their intense mother-child mutually supported relationship, with its intertwined erotic and erotized aspects, must have developed in transference and counter-transference. I would appreciate it if you could explain more about it.

Dr. Basak brought up many loci of study, and I am grateful for them. I sincerely appreciate your thorough elaboration stemming from the Asian culture of child rearing, which must form our foundation, possibly structured by a slightly different principle at a deeper layer of the mind.

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Invited Paper and Discussions
Discussion

Discussion

Masatoshi Ikeda

Member of the IPA and JPS

A psychoanalyst

Professor at Teikyo University, Graduate School of Liberal Arts, Division of Clinical Psychology

Thank you, Dr. Basak, for your wonderful lecture.

I also appreciate your giving me this valuable opportunity to discuss it today.

When I was first asked to be the discussant for your lecture, I wondered if I should accept this responsibility or not.

This was because I am not good at English, foreign languages, or meeting people from other countries, especially from Europe and the United States. This was similar to my being asked to play the guitar or board a plane, both of which I try to avoid if I can.

This is not just me, but it appears that there are still many Japanese people in awe or dread of other countries, and who fear and idealize them, especially Western countries. On the other hand, as a reaction to this, there are many nationalistic people who blindly praise everything about Japan.

I was therefore pleasantly surprised to learn of your interest in, and profound understanding of, the achievements of Japanese psychoanalysts of the past. I feel that we have many things in common, that we are "on the same page."

Japan has been both directly and indirectly influenced by India.

By way of an example, let me cite my personal experience.

I practice *Shorinji Kempo*, which is a type of Japanese martial art. It is said to have been established by a Japanese individual who learned the skills that Bodhidharma, a monk from South India, had introduced to China. The Ajase Complex, which you discussed in your presentation, is a concept based on a legend of Magadha, a kingdom in East India.

I sense a special meaning in the fact that you have once again taken up these diverse ways of thinking that originated in Japan, and have spoken about them today.

Discussion: 20221204 JPS Tokyo Meeting

Masatoshi Ikeda, M.D., Ph.D.
Member of the IPA and JPS
A psychoanalyst
Professor at Teikyo University, Graduate School of Liberal Arts, Division of Clinical Psychology
359, Otsuka, Hachioji-shi, Tokyo, 192-0395 Japan
m-ikeda@main.teikyo-u.ac.jp

As Dr. Okada noted, we have changed our lifestyles over the years, as shown in our shifting from using traditional Japanese-style toilets to Western-style toilets. About 30 years ago, when practicing *Shorinji Kempo*, my opponent gave me a kick that caused damage to my left quadriceps muscle. I was unable to squat and use Japanese-style toilets for three months, so I had no choice but to use a Western-style toilet instead.

As symbolized by things such as these, at least in the foreground, Westernization has steadily progressed among the Japanese people and Japanese society, which is gradually adopting global norms. Even now, however, Japanese mothers lie down with their children to put them to sleep for a longer period than in Europe or the United States. The Japanese-style mutually cooperative self, nurtured in the context of Japanese families and school culture that favors dependence, is liable to be negatively evaluated in Europe and the United States. However, this self may work in a more adaptive fashion in Japanese society than would a Western-style mutually-independent self. The characteristics of the Japanese language, in which the subject of a sentence is not directly stated, may reflect a culture of non-verbal communication that contains elements of ambiguity.

I would now like to discuss a few topics, although I'm afraid they are rather fragmentary.

In your lecture, you discussed the advantages and disadvantages of not separating things clearly, and seeing a slow breakdown of illusions. I agree with your views.

But there is one thing I would like to confirm with you once again. First, according to Dr. Takano, in Dr. Kosawa's and Dr. Okonogi's versions, the Ajase Story goes like this:
Although it was to win her husband's love, Queen Idaike wanted a child. She had a hermit killed in haste and conceived a child. This was because, in dying, the hermit prophesized that he would be reincarnated as the child, and that, after growing up, the reborn son would kill the king, her husband. Idaike was terrified by the hermit's rancor, and tried to kill her son, who was named Ajase.

I believe that it is not necessarily just "the birth of Ajase itself that was rooted in maternal acrimony and betrayal of Idaike, who herself was struck with dreadful anxiety, fearing the loss of her husband's love." In any event, Idaike attempted to bear and kill a child to regain her husband's love or to protect her husband's life. I believe there is an early triangular relationship here.

What, in your view, Dr. Basak, is the difference between this, and what Klein refers to as the early Oedipus complex?

In connection to this, you stated that *amae* is related to maternal forgiveness, reparative guilt—could this be a depressive position?—and primary narcissism. I found this view very interesting.

Let me move on to the next topic.

In your lecture, you discussed the role of language in reaching the unconscious, stating, "Language is the symbolic route to the Unconscious, and thus the query into the Japanese language—its articulation, symbolic references, and silences—has acted as a primary pathway to understanding its people, its psyche, and culture. The site of silence in the Japanese language is very significant." You emphasized the importance of a language's articulated sounds, symbolism and silences.

In India, English may be close to your native language, but what do you see is the significance of receiving psychoanalysis in one's native tongue?

I would like to ask you a few more questions.

I think I understand that "Internalization of the Prohibition of Don't Look by the maternal object herself" brings about a masochistic caretaker, i.e., the course of an internalized masochism in maternal love, self-sacrifice, and, ultimately, the "dead mother" (Green, 1986).

However, I am not too sure about your statement, "Overt externalized love and care may often act as a guise for shrouding acute anxiety." Does this mean that the masochistic caretaker is creating a wall of defense against acute anxiety?

Concerning your question, "Does it indirectly echo a punitive act on the maternal object, which would probably invite an act of *amayakashi* by the phallic attack towards femininity?" Can you please explain in a little more detail what this "act of *amayakashi* by the phallic attack towards femininity" is all about?

Does this mean that punitive acts towards the mother object are phallic acts or attacks directed towards femininity, and that an act called *amayakashi* is brought about indirectly?

On the other hand, the father's 'evolved cultivation of *amae*,' which may be an evolutionary type of refinement of *amae*, helps nurture mother-child bonding in the context of Japan's culture of triadic sleeping together in the same bed.

Am I correct to understand that these combine to foster the mother-child relationship in the context of this culture of the triadic sleeping together of the mother-child-father, and procrastinate the Oedipal confrontation between father and son?

Doi states that the mind of *amae*, which is based on a close dyadic relationship, has become lost, and irresponsible *amayakashi*, or pampering/spoiling people, and *amattare*, or becoming spoiled/dependent, have been spreading.

Is it appropriate to think that a culture with these kinds of ambiguous boundaries leads to pathology on the one hand, but also leads to richness of some kind?

I found the two cases you had presented extremely interesting.

I would like to begin by commenting on the first case.

In Japan, many married couples are said to not fully enjoy sexual intercourse, resulting in the prevalence of sexlessness. However, this is, to some extent, regarded as normal, and I don't think it necessarily causes many patients to present neurotic symptoms such as aphonia or trembling.

Lack of sexual contact may detract from the richness of life, but I also believe that this is associated with our culture that tolerates certain kinds of ambiguity, and may have aspects that lead to security and stability. What is the situation in India?

Next, I would like to comment on the second case.

In Japan, we are seeing numerous instances of people withdrawing from society for many years, beginning in adolescence. There is what is commonly known as the "8050 problem," in which children in their 50s (mainly sons) depend for everything on their parents in their 80s. This is said to pose a serious social risk that is turning into a crisis. I believe that it may be influenced by the so-called culture of a child sleeping between his/her parents, like the Chinese character for "river."

Do you see this sort of a situation also occurring in India?

Are there children in India who are unmarried and unemployed, and live with their parents?

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Important Reference Paper (Interdisciplinary Studies)

[Original Paper]

Becoming drawn into a primal-scene

Osamu Kitayama
private practice

Abstract: In this paper, I want to focus on the primal scene, meaning a child's witnessing his or her parents' sexual activities: an issue that is known to be taboo. In the myth that describes the birth of Japan, the death of the maternal deity which the paternal deity witnessed on breaking the 'Prohibition of Don't Look,' was due to their sexual intercourse. Not a few Japanese *shunga* prints depict children as observers and participants in the parents' sexual acts. This is related to what Japanese scholars studying Ajase-Complex refers to as the culture of parents sleeping with their child in between, like the Chinese character for 'river,' (川). In this threesome situation, by having the mother doubling her body, or her role, as both a wife and a mother, the child, who has been elevated to the same position as the father/mother by sleeping together with him/her and coexisting with him/her, risks becoming drawn into the parents' sexual activities. Taking into account the pathogenicity of the primal scene, we must discuss possibilities of traumatic involvements that were suggested in Freud's case reports such as "Wolf Man." We can expect to see a situation in which phantasy and reality become mixed together, causing two types of pathological involvements. In the latter half of my report, based on cultural searches, I would like to limit my clinical materials in this presentation to eyewitness testimonies, of "the murder of a mother by the father" in both a boy's and a girl's case. Talking overtly about a primal scene, the patients describe their helplessly witnessing the murder of the mother by the father. Based on the cultural studies and clinical examples, I stress the likelihood of, and the pathology of, people in our culture frequently experiencing participation-type primal scenes, of a child sleeping together with his or her parents.

Key words: Prohibition of 'Don't Look', primal scene, Ajase Complex, participation-type, *amae*

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Osamu Kitayama, M.D.
private practice
4-16-13 Minami-Aoyama, Minato-ku, Tokyo 107-0062, JAPAN
e-mail: umeyon@me.com

Introduction~ The Prohibition of 'Don't Look'~

The question of whether the ways of Japanese sexuality within the context of Japan's culture are the same as, or different from, ways in other cultures, and if so, how, must be asked with care. The author's discussion on the "Prohibition of 'Don't look'" (Kitayama, O.,1985, 2010 & 2017) focuses on the taboo of people 'not wanting to see,' and 'not wanting to be seen.' It is also deeply involved with the 'Japanese people's resistance' to the sexuality theory of psychoanalysis. I have examined this theme in Japanese, published my thoughts in English, and had them investigated both in Japan and overseas. However, I believe that these still do not cover enough area, so I wish to ask for your help.

In this presentation, I want to focus on the primal scene, meaning a child's witnessing his or her parents' sexual activities: an issue that is known to be taboo, even in discussions. However, in the myth that describes the birth of Japan, the death of the maternal deity which the paternal deity witnessed on breaking the 'Prohibition of Don't Look,' was due entirely to their past sexual intercourse. In other words, the story of Izanami and Izanaki, who got married on Onogoro Island, having sex, and creating various deities and different countries, and the maternal deity Izanami then giving birth to fire deities, and dying after having her genitals burned, suggests a direct connection between the parents' coitus and the mother's death. In the story of the Crane Wife, which uses the same 'Prohibition of Don't Look' theme, we can imagine that the piercing of the Crane Wife with an arrow at the beginning symbolizes a sexual act, and the loss of a mother object due to the exposure of the injured crane can be interpreted as a 'death while engaging in a sexual act.'

Stories of prohibiting a male figure from looking at the death of his beloved female partner can be seen not only in Japan, but also sporadically in cultures around the world. One of the most famous is the Greek story of Orpheus being told to not look at his dead wife Eurydice as he rescues her from the Land of the Dead. The husband breaks this prohibition by turning around to look at his wife who is following him, and ends up losing her as she is drawn back into the Land of the Dead. We find no major cultural differences in the tragic setting of the 'Prohibition of Don't Look' in which the audience and the readers witness, together with the husband, the death of the wife as a result of the exchange of love between a man and a woman. One thing that should be noted, however, is that, while the Japanese mythology maintains the final tragedy and the notion of '*minikusa*, or hard to see' (a homonym with *minikui*, meaning 'ugly'), stories with happy endings similar to those that are popular in the Christian world such as "Beauty and the Beast" and "The Frog Prince" may be said to be, more correctly, recent fabrications or editing, or, in other words, defensive elaboration based on beautification and idealization by 'the miracle of love.'

The reality of sleeping with the father, together with the mother

On the other hand, despite this being a taboo, Japanese culture possesses numerous prints and pictures in rich variety that depict sexual intercourse between a man and a woman. Although I have eliminated them here in this paper, *shunga* or erotic prints that show the genitals in gigantic form, fully attest to the ways of our sexual thoughts. As indicated

by the fact that they were also called "comic pictures," these paintings, edited to reduce anxiety, fear and a sense of guilt, invite maniac laughter among their beholders.

Interestingly enough, not a few Japanese *shunga* prints depict children as observers and participants in the parents' sexual acts. Prints of this type, in which children take part, are rare throughout the world. This may attest to the fact that children in Japan have many opportunities to become drawn into a primal scene. The artistic convention of putting small animals, such as cats and dogs, in places where they can watch these acts, may suggest the beholder's animal-like mindset.

On looking at my studies of *shunga* [as in the art book by Hayakawa, M.(2000)], Keigo Okonogi used to say personally that this was related to none other than the Ajase Complex (Okonogi,K.,1978 & 1979) itself. In the story of Ajase which Heisaku Kosawa *et al* [see the papers in special issue on Ajase Complex, *Journal of The Japan Psychoanalytic Society.* Vol. 4(2022)]. used as their basis, Ajase, the son, learns that his mother covered her body with honey and secretly visited her husband (Ajase's father) in prison to feed him. Ajase becomes enraged and harbors a murderous intent. The mother resigns herself to her husband, who is Ajase's father, saying something like "Go on, help yourself to the honey covering my body." The 'filthy' image of a father licking the mother's body, coated with honey, in the same way as his son, is an important climax in the family participation-type sexual experience. Disgusted, the child thinks that the betrayal was made by his mother, and thus directs his anger towards her.

I believe that bedroom circumstances are behind this tendency of anger being directed at the mother but not towards the father. This is what Okonogi refers to as the culture of parents sleeping with their child in between, like the Chinese character for 'river,' (川) and the state of a threesome comprising the mother, the child and the father long experiencing sleeping together. For example, a picture in the book *Hanafubuki* drawn by Utamaro, depicts the mother, who is sleeping with her child, moving parallel towards the father. By having the mother doubling her body, or her role, as both a wife and a mother, the child, who has been elevated to the same position as the father by sleeping together with him and coexisting with him, risks becoming drawn into the parents' sexual activities.

Seen from a classic psychoanalytic viewpoint, this sort of situation might delay the Oedipal triangulation in which the child competes and clashes with the father. Moreover, the parents and the child come to coexist in the primal scene at an extremely close distance. As depicted by Harunobu in his *shunga*, sudden disillusionment and exclusion occur within a triangular relationship as the child discovers his parents' coitus proving his mother's duality. The print shows the co-existence of childrearing and sex, or 'this and that,' not the dichotomy of 'this or that." Harunobu's observations led him to illustrate, in a child's facial expressions, his negative emotions of having been 'left out in the cold' from the three-body relationship, and literally kicked out of the cozy mosquito net. If things were going well, without any serious involvements, this might be regarded as a comic scene. At the same time, however, the child's agony caused by his exclusion likely causes a clinical problem as well. From the perspective of childrearing support, a psychologist said that, since the mother is being coveted by her husband on one side and her child on the other, she should enjoy her popular status more. Taking into account the pathogenicity of the primal scene, however, things may not be that simple. I feel that we must discuss

the types of serious emotional confusions that were described in Freud's report on "Wolf Man," such as anxiety, fear and eeriness.

What is a participation-type primal scene?

In the 'threesome' picture *Azumanonishiki* created by Hokusai, the father approaches the mother, pressing her to choose 'this little kid (= the father's penis) over that little kid.' Here, the man's penis has the same rank as the child, and the 'little kid' which, in Japanese, signifies a penis, is clearly getting drawn into the sexual act. Moreover, the following novel by Hiroyuki Itsuki shows a child taking part in his parents' sexual intercourse, as if it were a festival of sorts:

> "In his dream, he (Shinsuke) was making love to Tae (his stepmother), together with his father (Juzo). Tae was responding to both Juzo and Shinsuke while cooing like a pigeon. With Tae's white body in between, the two intertwined their arms, exchanged smiles, and vigorously moved their bodies alternately from the front and the back. For Shinsuke, this certainly did not carry an obscene image. He felt it like a refreshing, vibrant festival that further strengthened the solid bond among the threesome of the father, the son and Tae." (青春の門 *The Gate of Youth*)

Instead of a witness-type primal scene, this novel testifies to the potentials of a participation-type primal scene, of a child joining his father to engage in sexual intercourse with the mother. I myself have heard patients narrate their manic participation experiences in my clinical practice. Here, with generational differences and exclusions having been ignored, all the participants had become monkeys and experienced intense excitement.

Thus, our psychoanalysis should transcend its idealization and romanticism, and instead discuss the participation-type primal scenes that are likely occurring under diverse conditions. Specifically, however, discussions that cover too diverse a scope are expected to occur; the potentials of various pathologies that accompany the family's sleeping together during one's infancy, cannot be grasped in their entirety, or sorted out, simply by referring to a person's individual clinical experience alone. We must also emphasize that this culture of sleeping together nurtures not only pathology, but also the Japanese people's *amae*, or interdependence, or a sense of solidarity (the Japanese word is '*tsurumu*,' meaning 'to get together'), and a feeling of security and peace of mind.

Needless to say, a young child's experience of interpreting his parents' sexual intercourse as something violent and animal-like, may be a phenomenon that transcends culture. So, even in Japanese culture, I believe that eyewitness information such as "my mother is being killed by my father" is something we can often hear. And, based on cultural searches such as those described above, I would like to limit my clinical materials in this presentation to eyewitness testimonies, of "the murder of a mother by the father" in both a boy's and a girl's case. To this, I would like to add the potential of 'active participation in a primal scene' because of the family sleeping together. I then believe that we can expect to see a situation in which phantasy and reality become mixed together, causing two traumatic involvements such as those cited hereunder.

(1) The possibility that a child who identifies himself with his father, rapes his mother alongside his father. The child will also have a part in his father's matricide; merely looking on as a bystander would likely constitute collusion.
(2) The possibility that a son and a daughter who identify themselves with their helpless mother who is being killed in a passive fashion, feel that they are raped or killed by the father, together with the mother.

Therefore, in the latter half of my report, I would like to describe two patients who talk overtly about a primal scene. In both cases, the patients describe their helplessly witnessing the murder of the mother by the father. I will also be discussing not only visual involvements along with anxiety, fear, and eeriness, but also excessive emotions felt by the witnessing participants such as disgust/hatred, contempt, ugliness and filth. I would like to stress that, physically, one often experiences dizziness and nausea accompanying the spinning and rotation of "becoming drawn into."

A male patient: "Fainting"

This was a 55-year-old businessman who talks about 'having been excluded' throughout his life. The reason for his coming to my office was that, although he had achieved success in his business, he had broken down, personality-wise, and wanted to rethink his life. Specifically, he complained that he was not respected as an organization man, and was unpopular wherever he went, since he would only speak polite and empty words.

For a long time, he had undergone cognitive behavioral therapy but ended it after he changed jobs. He had lots of interesting things to talk about in diverse fields; his associations were rich, and, from the initial stages, he described a whole series of his dreams. Because the content of what he spoke about was extremely rich and diverse, and since the subjects of his conversations tended to wander, I adopted the restrictive setting of a once-weekly session, done face-to-face.

He idealized me with a passive attitude. While this was helpful in forming a therapeutic alliance for doing search work, he always adopted a self-deprecating attitude, and could never speak assertively or say aggressive things.

He continued to recount masochistic episodes, such as being bullied ever since he was small, being punched by his younger brother, and laughed at. His grandmother repeatedly talked about her expectations of him, that he should be hired by a good company and move up its hierarchy.

The relationship between his mother and his father, who had taken over the family business, was confusing: their relationship looked both good and bad. What the patient always recalled was a scene that took place when he was about four years old, of his parents quarreling. A hellish scene of his father, a drunkard, attacking his mother, shouting, "I'm gonna kill you," and strangling her, has become one of the patient's most traumatic memories. The patient, who was still a child at the time, was thinking over and over, "I'm sorry, I'm sorry (for not being able to help you, Mother)," then eventually fainted. He said that when he came to, he was in an ambulance (he was unsure who had called an ambulance in the first place).

What he repeatedly recalls in parallel to this incident took place when he was around

six years old: a scene in which his mother was about to be dragged out of their home, coerced by an acquaintance, while his father was absent. Here again, the patient simply trembled, unable to do anything despite his mother resisting and seeking help before his eyes.

In the end, it became clear that the patient had become drawn into an ugly [Translator's note: the Japanese word for this is *minikui*, which can also mean "difficult to see or watch"] scene, and, unable to take it in, fainted. The scene that he could not watch was a phantasy in which his mother was being killed or raped, and what he had recalled as a circumstance that should be added, was something that had taken place years ago, when he was a little child, sleeping with his mother lying beside him. Because the bedroom was small, and the family used just one *futon* mattress, the father was sleeping on the opposite side of the same *futon*. The patient said that the parents' feet were entangled and crept about, which he found eerie. Even after he began to be taken care by his grandmother in another room, he occasionally spotted the grandmother peeking at scenes of the parents having sex. He therefore said that, although a little child, he, too, appeared to have gotten involved in this snooping activity. Later, despite knowing that fierce quarrels and lovemaking exist in a married couple like the two sides of a coin, he himself was unable to consider 'loving each other' and 'quarreling' coexisting in his mind.

To "filthy and ugly" incidents from his memory such as these, a reconstruction occurred in the patient, as a little child: He felt dizzy and helpless, and, confronting the imaginary results of seeing his mother killed—which in fact might have been possible—he fainted as if he himself had also been killed. Looking at them squarely once again now, he had no choice but to admit the fact that he himself had been drawn into sexual acts and murder, through his experience of the primal scene in an ugly and sinful form, as well as their hopelessly helpless repetition.

Afterwards, the patient began saying that parents have two sides, the front and the back, and that, while they quarrel in the front, they have sex in the back. He admitted that he, too, had two sides, the front and the back. He added, "The fact that I'm coming here to you is also a behind-the-scenes story, you know?" Verbalization and reconstruction such as these, being 'held' or supported by a therapeutic framework, help to maintain his sanity as an intellectual being. It appeared, however, that the problem of disillusionment with me was being put off by idealization of me.

A female patient: "I feel nauseous"

This was a 50-year-old housewife who works part-time. Her husband, the same age as her, operates a store. The patient was a mother to multiple boys, and had enjoyed fairly good health. Several years before coming to my office, her father died of an illness, and, one year later, she lost her mother due to an illness. During the following year, the patient had lived her life normally. Gradually, however, she began going frequently to the hospital where her mother had died, lamenting intensely that she wanted to die. I thought that her symptoms were hysteric in nature, but soon, a mechanism began operating between her dazed state and sanity which I had no choice but to diagnose as 'severe dissociation.' Treatment began as once-a-week psychotherapy, with the sessions moving on to four times

a week after about eighteen months.

From the early stages of treatment, she talked about her primal scene experience that she could not speak of to anybody else. "When I was small, I was sleeping in a threesome, with my father and mother. It appeared to me that my father, by having sex with my mother, was trying to kill her." She said, in tears as if spitting out, "Along with my mother, my father raped me, his daughter, with his penis. At the same time, being helpless, I felt that I would be killed, and wanted to die," and continued to talk about her involvement-style primal scene experiences.

After marrying, moreover, she held a negative attitude towards having sex. She felt as if she was being made fun of by her family, and there was countertransference on my part also, of wanting to tease this woman.

Although she sometimes exhibited intense regression, I was able to 'hold' her during our sessions. She came to the sessions on time, left the office more or less on time, and paid the fees without fail. Along with androphobia and the fear of being penetrated by a penis, she hated overweight men and men who left their nose exposed while wearing a face mask. Countless numbers of times, she brushed away, with her hand, the possibility of making filthy contacts.

Her attitude clearly became rebellious after the third year. She focused on the fact that I merely listened to what she said without taking any notes for record-keeping, and began talking about her persecutory phantasies, of being made light of by me. Sometimes, she mentioned weekends and long holidays, and could not help telling me, "After I leave the office, I bet you flirt with your other patients." However, despite accusing me of most likely looking down on her, she then reversed her attitude, and revoked her comments numerous times with apologies.

Soon, a part of her that remained a small child (a boy) with halted growth and development, slowly appeared and took center stage in how she spoke as an individual with a dual personality. Around the time that Peter Pan syndrome began to make news as a separate personality, the patient accidentally skipped several steps while going down the stairs at a train station, fell, and broke her fingers. At a session during this period, while listening to her free associations and allowing my attention to float while continuing to understand her ways of being, I heard a little boy, sitting in a corner of the couch, looking dissatisfied and mumbling, "Oh yeah? I don't think so…"

Because of this episode, I continued to interpret her division/splitting between a boy and a girl. I must say that it took many years until the considerably serious division/splitting of the two children—a boy who asserted himself and made fun of others, and a girl who retracted this and apologized—came to be mitigated, allowing them to coexist more harmoniously. Needless to say, the gradual process was important. What is more important for today's presentation, however, is that the sexual aggressiveness of the separate male personality of this passive woman, and the division/splitting of the two people, had derived from her traumatic experience of viewing a primal scene itself.

Later, the patient and I laughed out loud when she protested to me, saying, "You must be flirting with your other patients," then retracted her outburst and apologized, embarrassed: "I've said something I didn't mean at all: I'm sorry." Gradually, she became able to accept my interpretation, "You must actually be the one who is making light of

others." For example, it was about the fact she was brushing away sexual intercourse and the erected penises by becoming "nauseated by them and vomiting"; I also pointed out that her having trouble remembering and mastering my interpretations and the understandings that I had conveyed to her, was because it was incomprehensible to a little girl, and also because 'the little boy inside you is spitting them out so you cannot remember or master them."

One thing that eventually became clear about this was related to the fact that, in the process of the patient coming to fear her parents' sexual intercourse, she became even more scared after watching rabbits engaging in sex, doggy-style, from the back. In other words, she appeared to have 'animalized' human sex, and thought that "Every one of them is a beast." One of the reasons she dreaded sex more than anything was that she, as a little boy, would be raped, get castrated and die as a result.

She admitted that she regarded sex as "a low-level matter," and came to gain insight, "Since you watched your parents having sex, your regarded them as animals and mocked them. These animals, made furious by being mocked, came to attack you. These events are all occurring in your head." Thanks to transference and its dramatization, the patient came to apologize, "I'm sorry for saying things I didn't really mean," and admitted also that a phantasy of me, "flirting with my other patients" was only inside her mind.

I then conveyed to her, "I believe the reason you spit out my interpretations when outside my office" is "because you hate thinking about me as a person who examines and treats other patients." Saying, "I can't believe that you are thinking about other things, even during sessions," she had no choice but to admit that, even though I worry about different patients, I may listen to her story at the same time. The patient is therefore now becoming able to allow and tolerate, little by little, the fact that, beyond the 'mutual killing' of a man and a woman, she can see them snuggling and flirting, despite becoming confused, not understanding what exactly is going on as a whole, or, in other words, experiencing spitting them out in her head.

Discussion

Conscious memories have become easy to understand, thanks to *Nachträglichkeit*, or afterwardness, and its subsequent development. Despite this, early-stage primal involvements are more 'mixed-up' things that cause dizziness and nausea, or are still undifferentiated and cannot be understood, so they were '*minikui*—difficult to see—ugly,' or 'filthy.' Here, I'm tempted to refer to the 'swamp' that appears at the opening of a Japanese myth. This is because of the description in which Izanaki and Izanami lowered the *nuboko*, or the heavenly spear, into a sea of mud, and stirred it, 'curdle-curdle,' round and round. When they raised the spear from the ocean, drops of seawater fell from the spear, dripping steadily, and formed an island. It was on this Onogoro Island that a nation was created through the deities' spectacular sexual intercourse. This image is none other than one of copulation and conception. In the beginning, it must have been the 'overwhelming unknown' that had been swirled (Fenichel, O., 1945).

Moreover, I recall what A. Green (1986) referred to as 'the dead mother.' What is interesting about the things that our Izanaki-Izanami myth depicts is the problem of

'looking at' the 'dying mother.' Yes, they are dying, but may perhaps survive. Their fates are "unknown (= *wakaranai*, in Japanese, which signifies the inability to understand, as well as the condition of being undifferentiated or mixed up)."

And, needless to say, for a patient to escape the sexual 'swamp' that he or she has become drawn into, and to survive, two things become important: The 'survival' of the analyst and the therapist himself (Winnicott, D. W., 1969), and not getting involved when talking to a child who had been excluded. Gaining such externality and objectivity from us analysts as a bridging third, the male patient whom I have reported as my case came to look at the original family while keeping a distance from them, referring to them as the 'naked tribe.' The female patient, for her part, became able to think objectively, "People in the old days did not regard this as harmful."

Conclusion

Based on the cultural studies and clinical examples described above, I have shown the likelihood of, and the pathology of, people in our culture frequently experiencing participation-type primal scenes, of a child sleeping together with his or her parents and getting drawn into the parents' sexual activities. As facts relating to the Japanese language that underpin these claims, it may be possible to point out the presence of obscenities such as calling the penis of an adult male, 'son,' and the meaningfulness of the proverb, 'badgers in the same hole' which is equivalent to 'birds of a feather' or 'companions in crime' (Kitayama, 2021), Many people laugh at these associations; for not a few patients, however, they may bring to mind the intense dizziness and nausea they felt when becoming involved in these 'threesome' situations.

Ukiyoe researchers state that painters of Japanese *shunga* depict genitals in exaggerated form, as if to 'show them off.' I personally feel that this concerns not only a child's problem; I believe that there may be parents who try to draw their children into the primal scene. I also feel that, regarding these lively and boisterous 'festivals and parties,' many patients experience excitement which they can never feel they have talked enough about, as well as death and horror.

My patients were both talkative. Experiences that people normally get involved in are like 'motion sickness' in that, if it gets worse, it causes intense nausea and dizziness. I hope to examine these problems concerning depth psychology once again, sometime later, this time involving healthy subjects.

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International Panel Discussion: The impact of psychoanalytic training on psychiatric practice and identity of a psychiatrist

Introduction

Naoe Okamura

Institute of the Japan Psychoanalytic Society

Summary: The panel, "The impact of psychoanalytic training on psychiatric practice and identity of a psychiatrist," was held on June 18, 2022, at the 118th Annual Meeting of the Japanese Society of Psychiatry and Neurology in Fukuoka, Japan. We invited three psychiatrists belonging to the International Psychoanalytical Studies Organization (IPSO), an international organization of psychoanalysts in training at the Training Institutes of the International Psychoanalytical Association (IPA). The discussion included how IPA psychoanalytic training has influenced the related fields of psychiatry, and how it differs across countries and cultures. The panel was organized and moderated by Naoe Okamura and Nobuaki Eto, with panelists Joe Behrmann from the US, Monica Bomba from Italy, and Nancy Pei-ling Yu from Taiwan, and designated discussant Yuri Seino from our society. The panel was live-streamed and recorded for video viewing for three months while being conducted on-site. The need for specialized psychotherapy training has not prevailed for most psychiatrists in Japan. This panel allowed us to show psychiatrists in Japan that intense training in psychoanalysis, with international standards, is available in Japan. It also generated shared awareness of the essential contribution that psychoanalysis can make to psychiatry, regardless of the healthcare system or culture. Each of the vignettes presented by these panelists provided an opportunity to know how they work in both fields of psychiatry and psychoanalysis, and how their psychoanalytic training deepens the way they understand and treat their patients in psychiatric care. Please note that the papers have been partially modified from the one which was read at the meeting to protect patient information.

Psychiatrists today select treatment for patients based on evidence, cost-effectiveness, and availability. There are global indications of a decline in the provision of psychotherapy in psychiatric practice and training, although various forms of psychotherapy are recommended for several mental illnesses (Moitabai and Olfson, 2008). We are in an era in which psychiatry is dominated by neuroscience, diagnostic checklists, and psychopharmacology.

Arguably, psychoanalysis is a controversial discipline. Its effectiveness has been

Naoe Okamura, MD, PhD
Institute of the Japan Psychoanalytic Society
SC Building 6th Floor, 3-4 Yotsuya , Shinjuku-ku, Tokyo 160-0004, Japan
e-mail: okmnaoe@mac.com

contested as its classical setting involves more than multiple sessions per week for several years. Such an expensive and lengthy method without good evidence is not on the clinical practice guidelines (Auchincloss and Samberg, 2012; Paris, 2017). However, psychoanalysis is practiced and recognized as important in many countries, including Japan. Notably, among 12,000 qualified psychoanalyst members of the International Psychoanalytical Association (IPA), 45 belong to the Japan Psychoanalytic Society. According to the IPA, an organization founded by Sigmund Freud in 1910, psychoanalysis is a theory of the human mind and a therapeutic practice. It emphasizes the influence of the unconscious, which goes beyond our conscious awareness.

The speakers of this symposium are members of the International Psychoanalytical Study Organization, a study group of IPA psychoanalysts-in-training. The six of us are also psychiatrists engaged in psychiatric practice in our local medical settings. We switch between psychiatry and psychoanalysis daily, two fields that are more separated than ever before, partly owing to today's medicalization of psychiatry. However, despite being separated, we find that the common denominator in these two fields is the human mind.

We, psychoanalysts-in-training, undergo extensive training to become qualified psychoanalysts. Unlike many other training programs, there is no fixed timeframe for completion. It is based on the three components of the training: taking personal analysis, conducting supervised psychoanalysis, and attending a series of seminars. The training to become a psychoanalyst is aimed at practicing psychoanalysis, but it is more than just the mastery of a method or technique. What is this training all about? Furthermore, what does this training mean from the perspective of a psychiatrist, who comes and goes between the two worlds? The speakers today will give us some insight into these two questions.

It has been argued that the training curriculum to become a board-certified psychiatrist in Japan allocates less time to psychotherapy than in other countries (Harada et al.,2017). In fact, for some young psychiatrists in Japan, learning to handle 50 outpatients in one day is a more pressing demand than learning psychotherapy because of the current state of psychiatric practice in the country, including the health insurance system and medical coverage (Okada, 2021).

I am honored to have a wonderful group of speakers here today for "What Psychoanalytic Training Has Contributed to Me as a Psychiatrist." You will hear how psychoanalysis is related to psychiatry and the psychiatric experience of each speaker. I hope this will provide an opportunity to consider psychiatry from a new perspective and to recognize the value of psychotherapy, whose basic concepts can be traced back to psychoanalysis.

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International Panel Discussion: The impact of psychoanalytic training on psychiatric practice and identity of a psychiatrist

Potential benefits of psychoanalytic training for psychiatrists who treat patients psychopharmacologically

Joe Behrmann

Institutes of the American Psychoanalytic Association

I am assuming that most of the psychiatrists who are listening to this presentation will not become psychoanalysts. The goal of my talk is to convince you that it is worth your time and effort to learn and practice psychoanalytic concepts through the informal pursuit of reading or attending lectures and conferences, formal training in a one to two-year psychoanalytic psychotherapy program, or full psychoanalytic training. I will attempt to demonstrate the relevance of this education by illustrating its practical help in my clinical practice by explaining my conceptual framework for approaching patients and then by providing a few clinical examples that highlight ways in which I utilize this framework in certain situations.

I was first exposed to psychoanalytic concepts and techniques when I began residency in 2000. Desiring a deeper understanding, I trained in a psychoanalytic psychotherapy program from 2008 to 2010. Since 2018, I have been training fully as a psychoanalytic candidate. Before entering formal training, I attended classes and conferences, paid for private supervision, and undertook my own psychoanalysis. As my training has deepened, I have felt more competent which has led me to feel more calm, creative, and spontaneous amidst balancing the needs and pressures of a large number of patients. This feeling of flexibility within a conceptual framework has also created more joy in my experience as a clinician.

Even though I prefer engaging in psychotherapy with patients because I enjoy connecting with them in a more frequent and deeper way, I feel a greater sense of satisfaction about contributing to society by medicating patients. About half of my practice is medication management, and I plan to maintain this balance indefinitely. The reason for my perception is that psychiatry emphasizes treating symptom clusters rather than treating the entire person. The consequence of this approach is frequent occurrences of inaccurate prescribing or excessive medication when clinicians target symptoms without fully considering the underlying dynamics of each patient.

I am not familiar with Japanese medical culture, but in the United States, there is

Joe Behrmann MD
Institutes of the American Psychoanalytic Association
122 East 42nd Street, Suite 2310, New York, NY 10168
e-mail: joe@joebehrmannmd.com

a belief that patients describe symptoms and then the physician makes diagnoses and actively treats these ailments.

Even in other medical fields, this approach has limitations. For example, if a surgeon repairs a torn anterior cruciate ligament or an endocrinologist prescribes insulin for diabetes, these treatments will not have their maximal impact without patients actively working in their healing processes.

The patient's need to participate in his own healing process is more pronounced in the psychiatric field. With all disorders, medications can be helpful, but they have repeatedly been proven to be only partially helpful. It is typical to experience residual depression, anxiety, psychosis, obsessive-compulsive symptoms, or posttraumatic disorder symptoms even when medications have been of some help. Specifically, antidepressants are deemed effective and approved by federal agencies when they improve depressive symptoms by just 50%. Across numerous studies, antidepressants have only been shown to fully relieve depressive symptoms in about 30% of people. This means that the majority of people treated with antidepressants continue to experience depressive symptoms that cause emotional pain and also limit their full potential in their personal relationships and in their work lives. Medications have the potential to relieve much suffering, but they are usually not fully successful when used alone in a treatment process.

While "personality disorders" are well known in the psychiatric world, psychoanalysis' emphasis of understanding how each person's personality functions is instrumental in guiding treatment. While not everyone has a full personality disorder, we all have personalities, with certain aspects helping us adapt to life and live fully and authentically and other aspects limiting us by constricting experiences that cause us anxiety or lead us to unnecessary conflicts that impair long-term relationships. These tendencies are so intrinsic to us that frequently we do not consciously reflect on these automatic behaviors and beliefs unless we are suffering a lot or are in treatment.

The common assumption is that psychoanalytic principles are invalid. If a clinician assesses how a patient's personality functions (both strengths and limitations), she can predict positive and negative aspects of the treatment process which leads to a calming mental framework as difficulties in the treatment process will naturally occur.

I believe a key role in a psychopharmacology is determining if therapy is necessary and providing a carefully considered referral if deemed necessary. While I believe that therapy can be helpful to anyone in psychological pain, the necessity of therapy depends on how constricting or how functional someone's personality operates.

If I am working with a patient who possesses several personality limitations, such as dealing with an unstable sense of self, engaging in relationships that involve excessive conflict and end abruptly, who displays a pattern of an inability to sustain jobs, or collapses psychologically when experiencing only mild or moderate stress, I will not be surprised that medication(s) are not working. When I recognize someone with many personality limitations whose symptoms have not been helped by medications, I typically recommend psychotherapy from the beginning. I will communicate that several medications have not worked (this is typically the case by the time a severely limited patient has been referred to me) as they do not address these underlying issues.

If the patient refuses therapy, I proceed to attempt various medications. During most

visits, I attempt to respectfully demonstrate how long-standing patterns are contributing to their problems. Many times, I am able to eventually convince a patient to work with a therapist by showing him ways in which his emotional pain is not purely biological.

Typically, I will state that medications may be able to partially improve their emotional state which, in turn, can help them engage and absorb the treatment process as therapy is difficult work. If patients are too overwhelmed, the intense emotional pain will limit their ability to grow from their experience in therapy. Ideally, patients reflect about relevant topics and emotions that are stirred up in sessions and do therapy on their own until the next session. However, if sessions cause too much pain, frequently patients shut down and limit much of their reflection until they attend their next session. Under these circumstances, medications prevent the collapse of therapeutic progress. I communicate that medications, healthy diet, exercise, and therapy all work together to improve their quality of life.

Conversely, if I believe a person has many personality strengths and good personal and work relationships, I will more likely believe that I have selected the wrong medication if he does not improve. I will trust that attempting various medications will eventually lead us to find a helpful one. While I may communicate that therapy would help anyone grow as a person and develop a more satisfying life, I present this treatment modality as optional as they are already adapting to the natural stressors of life and are leading meaningful and authentic lives.

On the other hand, if someone has multiple personality limitations, I will lower my expectations, but not my concern, for them. This helps me to not get excessively pulled into the pain and failures in their lives. When I am with the patient, I allow myself to get pulled into their pain, helplessness, and frustration. This allows me to emotionally understand what they and their loved ones experience, but I can mostly let those feelings go by the time the session or my day ends.

Maintaining a realistic conceptual framework helps me to consistently be supportive. Many times these patients have have difficult childhood experiences or biological vulnerabilities that have limited their lives. I do not tell them that they are emotionally stunted, but I do highlight that they are trying hard and point out the genuine good things in their life.

As I have been practicing for two decades, I will be surprised by patients that I feel that I am not helping state that they are extremely grateful for my help. Many times I have heard "You're the longest relationship that I've had," or "I've had several psychiatrists who have given up on me because they get frustrated that I don't get better." I believe many psychiatrists are so preoccupied with "fixing" all of their patients that they get frustrated and feel helpless when someone does not get better. When a patient is clearly resisting healthy choices and help from others, I believe that many psychiatrists feel saturated with frustration because they feel that the patient is consciously, rather than unconsciously, sabotaging her efforts. Many clinicians have the perception that being helpful only occurs if the patient's symptoms improve because they do not detect (or accept) the limitations in the patient's personality structure. I believe that even if I am not substantially helping improve the patient's emotional state or quality of relationships, I am providing a reliable relationship that does not end when he is acting in ways that typically drive other people away. It provides the patient with support even if he leading a life that most people would

consider unsatisfying.

So far, I have discussed how my understanding of general psychoanalytic principles guides my treatment approach. I will now share specific instances of how following, or not following, these principles has affected specific treatment scenarios. The first is a cautionary example of me noticing, but not truly respecting, a patient's resistance. "Bill,"a man in his 30s, on the surface appeared classically psychoanalytic. His father abandoned his mother and him when he was a small child which, naturally, devastated him. About six months prior to his first appointment, his mother died of cancer. His presenting complaint was experiencing extreme panic attacks that began long before his mother died but had definitely worsened since her passing. Bill brought his fiancé to his first session. After only a short courtship, he had proposed to her. He consistently looked at her when I asked questions, which made me think of a young boy seeking reassurance from his mother. Bill did not believe in therapy as he had already tried it and had unsuccessfully attempted the coping skills that he was taught. He also claimed that antidepressants either did not work or caused severe side effects. Only alprazolam had worked for him and that was the treatment he asked/demanded from me. I agreed to prescribe alprazolam if he agreed to also take an antidepressant and engage in weekly psychoanalytic therapy with a competent colleague. The therapy lasted for about six months, consisted of frequent acting out and a lack of reflection. He ultimately left treatment with both the therapist and me. My error was discounting his superficial and compliant responses to many interventions such as my speculation that the death of his mother likely activated his sense of being abandoned by his father and now he was really feeling alone in the world. Despite all of these forces potentially influencing his panic attacks, I ignored the extent that his responses to my verbal interventions seemed gratuitous. Bill was really seeking alprazolam and lacked the capacity, or did not desire, to mourn the losses of both his parents and attempt to figure out the best way to navigate his life in the present.

The next vignette has a successful outcome. "Stacy", in her 20's, presented with severe anxiety and mood dysregulation. She admitted that she was attempting to escape a conflictual home life. Stacy's parents divorced when she was in high school. There was frequent conflict throughout her childhood, and her mother was an active alcoholic until the patient was about 15 years of age. Stacy never developed the capacity for self-regulation. Although unresolved issues from her childhood flooded her, she was resistant to the idea that therapy could be helpful. Stacy would frequently request changes in her medications. I would comply with her wishes while also stating that until her underlying issues were dealt with, no medication would satisfactorily relieve her suffering. Although Stacy was intermittently suicidal, she abruptly accepted a job halfway across the continent. She finally sought treatment with a therapist when she was persistently suicidal. Accurately, the therapist did not feel that she could help Stacy while she was in such a crisis. After Stacy returned to St. Louis, she agreed to an emergency appointment with me and allowed her parents to join. I strongly believed that there were so many limitations in her psychological development that I emphatically stated that Stacy needed residential treatment that could provide an immersive and supportive environment.

While her parents understood that she needed this level of treatment, Stacy vehemently opposed this idea. While she voluntarily attended the program after her parents' strong en-

couragement, Stacy emphatically expressed her anger towards my recommendation during that session. Although, I felt a relief that her parents were supportive and that Stacy agreed to the intensive treatment, I assumed that I would never see her again as she perceived that I had betrayed her by this recommendation. I was surprised to receive a phone call several months later from Stacy asking to make an appointment. She had spent two months in the residential treatment center and then another three months in an aftercare facility. When Stacy arrived at her appointment, she revealed that the residential treatment had been immensely helpful. As of today, about five years have passed since she completed the program. Once convinced that leaving St. Louis was only way to ameliorate her suffering, Stacy now has a satisfying job, a strong group of friends, and a niece and nephew. She does not need to geographically escape as she has dealt with her internal issues.

In conclusion, an appreciation of the complex environmental and biological factors influencing personality development creates a framework for understanding the complete person and guides medication decisions amidst a myriad of symptoms and medication options.

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International Panel Discussion: The impact of psychoanalytic training on psychiatric practice and identity of a psychiatrist

The talking action and the joint work of psychiatry and psychoanalysis in the treatment of adolescents' emotional breakdowns

Monica Bomba

Child and adolescent psychiatrist, psychoanalyst of the Italian Psychoanalytic Society and the International Psychoanalytical Association

Introduction

The adolescents hospitalized in a child and adolescent psychiatric ward, going beyond the DSM diagnostic code, are often young people who have experienced an emotional breakdown, characterized by the loss of a feeling of existential cohesion. They appear, from the very first encounters, as people who carry the urgent need to transform the anguishing presence of strange sensations within their flesh, meaningless and terrifying, into a sort of apparently less disturbing body-shelter, where anxiety is dispersed, along with the possibility of giving affective meaning to their experiences.

These are young people who attempt suicide, who starve themselves, or who become violent against a life they seem not to be able to live, dominated by "concrete" thinking, visual, acoustic, proprioceptive sensations that terrify them as if they were in a state of hallucinosis inside their body.

A very primitive state of mind is observable: their thoughts and feelings seem fragmented into pieces, in a frozen, sensual, psychodynamic puzzle, but, when the therapy works well, during their hospitalization, patients seem to revive their bodies, and thus their minds, and, like newborns, become alert and curious about the sensations generated in themselves, during a quiet state.

Of course, this transformation isn't stable, and the patient will go back and forth, from the fragmented and sensorial way of functioning to the experience of a psycho-somatic integration, and vice versa. So, there is no claim of a change of the developmental path that has characterized an individual for years, or a healing process, occurring in just a few

Monica Bomba, MD
Child and adolescent psychiatrist, psychoanalyst of the Italian Psychoanalytic Society and the International Psychoanalytical Association
Via Panama, 48, 00198 Roma, Italy
e-mail: monica.bomba@gmail.com

weeks of hospitalization. Nevertheless, the importance of this experience of oscillating between different states of the mind, which is like a door that can begin to open onto new trajectories of growth, should not be underestimated.

In my experience, to take care of these patients it is extremely important to develop semeiotic recognition, intuition and clinical listening of all the communications of the patients. This was possible to me by integrating psychoanalytic listening of the unconscious communication into the psychiatrist's work.

I will go back a few more years and try to sketch some of the reflections made during my professional training as a child and adolescent psychiatrist and psychoanalyst.

The School of Specialization of Child and Adolescent Psychiatry I attended was directed by a psychiatrist and training psychoanalyst, Prof. B. After many years, I still remember my teacher's capacity to help the trainees, integrating into the medical-psychiatric practice, a psychoanalytic listening to the different possible ways of communication of the human being. From those days I have memories of intense and exciting exchanges with the colleagues on the topics of psychoanalysis and clinic.

One evening we were returning from class, and I was rather displeased with the post-Lombrosian neurologist content that had just been exposed by the lecturer. The teacher sketched the parallel between the skull shape of some patients and their psychiatric disorders or antisocial behaviors. I told Prof. B that it was a quite dangerous idea to be taught. He then provocatively told me that what one should learn is the capacity to stay in the spaces between different ideas and propositions. While talking to me, he made a gesture with his hands, designing his idea in the air, between us. He added that I should have created bridges between aspects that I might have felt distant one from the other, or even divergent, advising me not to get too attached to one while ignoring the others but to make links, imaginary lines that, in time, could have been transformed into my own way of becoming a psychiatrist.

In the next years, while I started my psychoanalytical training, it happened to me to look back on that moment several times, revisiting it from different points of view.

For example, I was sometimes astonished by the distance, and sometimes the divergence, I felt between psychiatry and psychoanalysis. However, their pairing in the child and adolescent mental health department I was working in was particularly fruitful. It might be because of the original and strong identity of this psychoanalytically oriented child and adolescent mental health department that sometimes new things, unthinkable before the moment they occurred, may have happened. This also allowed the development of a particular way of listening and treating adolescents' mental breakdowns. This way of working with acute psychiatric severe patients will be illustrated through a clinical vignette and Racamier's concept of "talking action".

Rosa

Rosa is an adolescent girl hospitalized for a severe form of anorexia nervosa. She was picked up from home and driven in an ambulance to the ward by a colleague who found her at home, presenting with an extremely severe weight loss and emaciation. Rosa had locked herself in the bedroom where she lived with her mother and one sister. She was

lying on the bed underneath a hovel of blankets and sweaters, in a dark, untidy and dirty room. The fact that the psychiatrist had intentionally looked for her at her house, showing sincere concern and dedication, convinced Rosa to open the door of her bedroom "for one minute", which allowed our colleague to see her and resulted in an ambulance taking her to the hospital the following day.

Upon her arrival to the ward, the nurse who welcomes her says with concern that Rosa "is a cadaver", "she's a standing skeleton". Rosa seems to play the role of Death and she seriously risks dying because of her severe state of emaciation. She is extremely agitated and angry, and she refuses to be hospitalized. I must face the emergency of the difficult admission of a furious and hostile Rosa.

When I go and see Rosa, I found her in great agitation and violent reaction towards all the people around her. She keeps everybody at a distance, sending away whoever tries to get closer to her, kicking and swearing. The other patients gather in the little common room, and they look scared; some of them cry. She shouts saying she wants to leave, and she wants her mother, hitting her bony fists on the locked door of the ward.

As I get closer and I look at her, I see a little child, angry and scared. I quickly find myself grabbing her wrists. Rosa turns to me, and she looks at me astonished, asking "What are you doing?!". I think about her low weight, and I realize I can easily hold her in my arms, so I decide to pick her up and it seems to me that Rosa is following the movement to hold her with spontaneity, though a bit surprised. As I take her to her room, which is on the other side of the hallway, I feel a change in the muscle tone. At the beginning, we are both stiff. Rosa shows a widespread muscle tension and I feel her body pointy and hard. While I find myself in that unusual situation, in the middle of the ward, I see a nurse looking at us without intervening; I think about Rosa who, now silent, authorizes me to lift her bodily and I feel my body losing tension. After a few moments Rosa relaxes and becomes "softer". Rosa's body, which earlier seemed to lean on her own bones and muscles, is now leaning on mine. Rosa starts to cry quietly, a sad crying. She whispers, "I'm alone, I don't have anybody". After that first full-contact, Rosa starts to eat and talk to me. She tells me about the "atavistic cold" that reaches her "inside her bones" (impossible to send it away, even by wearing many layers of clothes and blankets) and that stresses her out and makes her walk restlessly.

Therefore, I ask a nurse, whom I know is both sweet and firm, to wrap Rosa up in a sheet and a blanket, as if she was a newborn, keeping her head wrapped, as well.

Then I sit next to her, and Rosa says, "I look like an Egyptian pharaoh!". In that position she finally gets warm; Rosa starts to talk about herself and her life "before the illness" when she was pretty and she liked listening to music a lot and putting on make-up to go out with her friends.

She asks me: "I was about to die, wasn't I? ...my heart could have stopped?", as if that gesture had laid a *caesura* between "before" and "after". Now distinct, the "current Rosa" looks at the "old Rosa" as if it had all passed, as if she was a new Rosa who had nothing to do with death and with the anguish that overwhelmed us earlier.

In the first days of hospitalization, I noticed that Rosa would look around for me and stare at me for some seconds to convince herself to eat a little bit more or to talk to her father or to accept some of the nurses' initiatives. That peculiar eye contact seemed to be

Rosa's entrance door. Now she let me enter her rebuilding world.

When Rosa started to feel better, we were able to begin with the first psychological sessions. She chose to lie down on the couch, and she always brought her light blue blanket with her, the one we had used on the first day to wrap her up.

During the month of hospitalization, Rosa talks about her desire to get liquefied, to die by melting slowly, an overwhelming desire that she felt in the weeks when she was stuck in her house with her mother and grandmother and that still popped out sometimes now, in the evening, when she felt lonely. She talks about the day when my colleague went to see her at home and rescued her: "When the door opened and all that light came in, something happened…I realized that she cared about me".

Rosa was able to give herself a chance to live and she managed to accept and understand her need of being hosted at a therapeutic community and not going back home at discharge, until she would feel better. On one of the last days, she refers a dream: *"I find myself in a big house…the walls are painted in soft colors, peach pink…I am not alone, I find out that there are other people with me, and I am engaged in a common project with them. We must build something that I don't know… I meet a man, who must be the boss, who carries some project plans that are needed to lead the work".* Rosa associates with her treatment plan in the therapeutic community and feels a sense of safety in the presence of the man who is going to lead the work with her and the group.

The outcome of Rosa's treatment, which began in the hospital and then continued in the community and in a 5 ys psychoanalysis, was very satisfactory.

Some reflections in *après coup*

With psychotic patients, and often with borderline patients, words do not contain any messages. The empty meaning of the words is such as to generate "thinking through actions", more than "thinking through thoughts", and the words can represent a potential fraud for these patients (Racamier & Taccani, 1999a).

Thus, it happens that psychotic patients hate words, and, since they cannot do without them, they tend to consume them and wear them out (Racamier & Taccani, 1999b).

In the first meeting in the ward, a yelling and furious Rosa seems to be provided with *a resounding second skin*, which protects her from "formless dread" (Ogden, 1989): she gets stuck with a moan, and she repeats it for an uncountable number of times, as if she was trying to use up all the words. Yelling and repeating "I want my mom" seemed to be for her a way to stop and avoid thinking and feeling the emotions held in what she was saying, thus strengthening her psychic immobility. The words had also a relationship with the thoughts that she wanted and had to reject and so this yelled repetition was her way to use them up, as it happens when one uses something continuously slamming it.

Rosa was finding herself in a paradoxical dilemma: "to communicate represents a risk of dying, to not communicate is to die" (Ogden, 1989). Within this dilemma, the words are separating, rather than being a mean of communication. They are a sign of absence rather than of presence, and the act, the therapeutic actions, can have a higher, more substantial value of presence and psychic communication" (Ogden, 1989).

Hochman (1974) and Racamier (1989). suggest defining the therapeutic actions as

talking acts or actions, thus stating that a type of treatment that meets the needs of the psychotic or borderline patient happens through the talking action. Only from an alliance between an act and a word sense and meaning will follow. The talking actions oversee carrying a message (Racamier, 1989). They translate for the patient the presence and the understanding of the therapist, so that the patient can feel the presence and make experience of the understanding. The action played by the colleague who went to Rosa's room and opened the door to see her, in continuity with the action of taking Rosa from her waist and lifting her seem to be the result of a tuning with a Rosa's pre-verbal, pre-symbolic, primitive, neonatal need, which allowed a first communication, through the body, in the tonic dialogue, rigid-soft, cold-warm, to which Rosa responded naturally. An action that revealed to Rosa that she was not alone, thus allowing her to express her existential loneliness. I believe that the syntonization with Rosa occurred at a very primitive level, under the domain of the sensory proprioceptive experiences. We might glimpse in the movements of the first meeting with Rosa an experience of *primary sensory proximity* that allowed the patient to lay the bases to identify a surface on which to lay, generate and organize the experience of a space, a time and a limit of the self.

While she is wrapped, Rosa starts to daydream that she is looking like an Egyptian pharaoh; the mummy-death is still present in this image, but it takes on a less concrete meaning and, in its majesty, something that is far back in the past. Time changes and a *caesura* with the earlier yelling Rosa seems to take place. The dread of death goes into the past; Rosa talks about the danger (still present) as if it was already a distant memory.

The psychic feeling of being safe goes along with the physical perception of a narrow escape. In that moment of dread of dispersion (or liquefaction) of the self in a limitless space, the action of comfortably wrapping Rosa in a sheet and a blanket, in the nurse's presence and mine, helped her feel the support of a second skin. Therefore, the *talking object* (Racamier & Taccani, 1999b) blanket strengthened the talking action occurred earlier, providing the patient with a tangible, solid, protective, supportive, a sensory and interpersonal surface.

Also, the special gaze that Rosa used with me, afterwards, seemed to have a shaping and containing function, at a farther distance.

Starting from the meeting with our colleague, who, by opening her bedroom door, began to undermine the symbiosis with the girl's mother, Rosa became able to experience a working group as a type of "parental" (both maternal and paternal) container.

Conclusions

The fruit of the pairing between psychoanalysis and psychiatry and their joint work could be represented by a fabric, a mesh that weaves together psychoanalysis and adolescent psychiatry, creating a new surface of contact with which patients and their parents, as well as the operators who keep it alive, can experience themselves. A "space in between," in which it is possible to give voice, act, containment to even the wildest thoughts, so necessary for contacting primitive forms of communication, fostering the exit from the isolation of the shelter of the "right idea," in order to open to the encounter with the unknown, to the multiplicity of psychic life.

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International Panel Discussion: The impact of psychoanalytic training on psychiatric practice and identity of a psychiatrist

A psychoanalyst and psychiatrist: From being marginal to synthesis and integration

Nancy Pei-Ling Yu

Institute of the Taiwan Psychoanalytical Society

Dear Colleagues:

It is a great honor of mine to be invited in this panel discussion. In this occasion people from different continents gather together, for example our panelists here, Dr. Behrmann from north America, Dr. Bomba from Italy, myself from Taiwan, and local Japanese chairpersons, Dr. Nobuaki Eto and Dr. Naoe Okamura. We share the same identity of psychiatrists who seek psychoanalytic training. The question of integrating two different identities and the interplay between two different but closely linked disciplines are issues that, I believe, have long been in the background of our daily practice. Being a practicing psychiatrist in Taiwan, I'd like to offer some facts so that you might have a better idea about the context of my training background.

Taiwan was colonized by Japan between 1895 to 1945. The earlier psychiatric institutions were established by the colonizing government. After second world war Taiwan was taken over by the KMT government, the psychiatric practice and training in Taiwan changed from the Germany/Japanese tradition to American tradition. The medical charts during the colonization period were written in Japanese and German. Later they were in English and Mandarin. Initially the board of psychiatry and neurology was combined together. A training program for board of psychiatric specialist was proposed as early as 1968, but it was not implemented until 1980.

At present, the population of Taiwan is around 23,000,000 and by the year 2022, there are 1900 psychiatric specialists. The training program of psychiatric specialist requires three and half years of residency training in either medical centers or psychiatric centers. It takes another year of fellowship for the training of subspeciality, such as child psychiatry, geriatric psychiatry, subspeciality of addiction etc. Each year, there are a little more than fifty new residents recruited. In the training program, together with clinical works and seminars of basic knowledge, a training course in psychotherapy is included. The course consists of at least 18 hours of theory readings and a minimal of 200 hours of clinical

Nancy Pei-Ling Yu, MD
Institute of the Taiwan Psychoanalytical Society
2F-1, No.35, Sec. 2, Fuxing S. Rd., Taipei City 10665, Taiwan
e-mail: nancypeilingyu@hotmail.com

practice, in the form of individual/group/couple therapy plus supervision. The theory learning and clinical practice of psychotherapy are not limited to psychoanalytic schools. They could be cognitive behavior therapy, mindfulness, dialectical behavior therapy, Satir model family therapy or anything else. It is fair to say that even though bio-psycho-social model of psychiatric training remains as a principal purpose, psychotherapy is no more in the mainstream, not to mention psychoanalysis.

Now, I will share my personal experience and my reflections. After graduated from medical school, I chose psychiatry as my specialty. I felt a bit marginal when I heard my classmates talking about updated treatment of malignancy, or bragging about their techniques in the Operation Room. The TV series "Doctor X: Surgeon Michiko Daimon" is very popular in Taiwan, by the way. You can see how mystified and idealized a surgeon can be. On the contrary, psychiatrists are only called to ER when they think the patient is weird, too neurotic and demanding, or suicidal. After I entered my psychiatric residency, there came the era of psychopharmacology, neuropsychiatry, and molecular psychiatry. Nowadays, psychiatrists who continue to do psychotherapy in their clinical practice have become minorities. Luckily in the psychiatric center where I received my training, there was a tradition of critical thinking and respect of diversity. It functioned like what Bion called a "container", where my curiosity of connecting neurobiological knowledge and psychic functioning, my ambivalent feelings towards the way Taiwanese society manages psychiatric illness, and my uncertainty of how my future as psychiatrist was shaped could all be digested and contained. At that time, a few senior psychiatrists were enthusiastic in teaching psychoanalytic psychotherapy. It echoed with my sentiment of reading the Mandarin edition of Freud's "Interpretation of Dreams" for the first time, at the age of 18, when I was freshman of the medical school. I thought to myself, it was what I was looking for! After finishing my training course, I worked full-timely in the department of psychiatry of a general hospital for twenty years.

Training program recognized by the International Psychoanalytic Association (IPA) was not established in Taiwan until 2018, and I am one of the first few candidates. When I decided to do psychoanalytic training, I relocate my practice to a local psychiatric clinic. The requirements of the training program take up a significant proportion of my daily schedule. Personal analysis, theoretical seminars every Saturday afternoon, not to mention control cases and supervisions. These obligations made me chose to keep a part-time psychiatric practice. However, I have never thought of giving up my psychiatric practice because it remains my identity.

When I decided to pursue training in psychoanalysis, I was often challenged: why? I also asked myself: do I push myself to an even more marginal position among my psychiatric colleagues? What is in the feeling of being "marginal"? Is it my defiance in face of mainstream medical practice, or is it a narcissistic injury? Psychiatry has long been seen as touching on the interface between "hard" science and human or social science. Psychoanalysis today, if I may say so, is not regarded as Karl Popper's "true" science. How would psychoanalytic training impact my psychiatric clinical practice?

These few years of psychoanalytic training contributes in several different levels in my

daily psychiatric practice. Firstly, I would be more sensitive to the underlying dynamics between me and my patients. Underneath the doctor-patient relationship, there lies a transferential enactment; and I pay more attention to unconscious meaning of symptoms and the repetition of object-relationship in a patient's help-seeking behaviors. I recall a patient, a young schizophrenic girl who was only 14 years old. It was in my first year of residency, and she was taken to our ER by a senior colleague because her parents were divorced and none of them was able to care the patient properly. This young girl visited our senior colleague's clinic; she wouldn't leave. Her symptoms included a well-developed delusion, mainly concerning her family romance. She declared that she was Princess of Laputa, (yes, as in Hayao Miyazaki's movie, "Laputa: Castle in the Sky"). Towards the end of her hospitalization, my young patient was upset at me because I was unable to persuade her parents to bring her home. She shouted at me, saying that I was incapable, and that I could not even manage to get her ID card for her. I don't remember the details of contacting the divorced couple back and forth to figure out a discharge plan, but I do remember my feeling of frustration and vulnerability, and my tears when the young girl shouted at me. Had I applied psychoanalysis-informed understanding to the situation, I would have more empathy about the girl's frustration and vulnerability when facing the conflicts between her parents. I would have realized that my feelings was in fact the result of projective identification, and the content of her delusion is her fantasy of manic defense.

In Taiwan, health care expenses are covered by National Insurance System, which means that medical resources are cheap, immediately accessible, and the quality of healthcare is highly praised. Meanwhile, patients tend to see medical staffs as omnipotent, and they tend to infantize themselves. Psychiatrists are also expected to work efficiently, if not magically. There is another TV series called "Dr. Rintaro, psychiatrist", in which the interaction between a psychiatrist and his patients are dramatized. Nevertheless, we see the image of a devoted and creative healer. Patients and their family would expect doctors to play similar roles. If the expectations are not met, idealization is turned into devaluation and anger. Even if family and patents are eventually aware of the limit of medical science and that of the health care system, disappointment and frustration are inevitable. These negative feelings are displaced onto their doctors. Later, anger/aggression and the accompanying unconscious guilty feelings, together with awareness of their greediness, cause defenses. Aggression and greediness are split off and projected onto the once-idealized objects. The patients accuse their doctors of being selfish and impatient, saying that doctors insist on prescribing medication, instead of spending time listening to them.

Psychoanalytic training helps psychiatrists to be aware of these dynamics and avoid enactment under the sway of projective identification. Being a mental health worker serves the purpose to fulfill one's narcissistic need. I am no exception: who would not like to see patients get recovery or improvement? Detecting transference/countertransference and avoiding taking things personal are the lessons I learn. Sometimes I notice myself prescribing more medications in circumstances when I feel frustrated by the lack of improvement of my patents, after attempts of psychosocial intervention. For me, medication serves not only as one important treatment options of psychiatrists, but also a key symbol, something I may turn to when I feel frustrated after non-pharmaceutical treatments. In the field of psychiatry, there is a tension between biological and psychological trends.

Although preferably these two trends should be synthetic and integrated, one might use splitting and idealize one of them when feeling frustrated.

Secondly, psychoanalytic training helps me to function not only as a doctor, but also as a team leader. Regardless of locations of practice, management of psychiatric patients is a team work, and psychiatrists are the leader of their team. My training hospital, “Taipei City Psychiatric Center”, is composed of multiple departments of almost all kinds of psychiatric services—out-patient clinics, acute and chronic wards, day hospital and community services, substance abuse, forensic psychiatry etc. In general hospitals or local clinics, I work with yet other group of patients: those with comorbid physical illness, those who seek “solutions” for their daily suffer of difficulties in intimacy, stressors from job, and parent-child conflicts. Psychiatrists work with psychologists, social workers, nurses, even administrative staffs. Psychoanalytic understanding helps me to identify the dynamics in my team, and the possible countertransference/ projective identification/ enactment of the team when facing patients and family. In work group discussion, Bion’s theory helps to see through the group mentalities, and Balint group often offer useful peer support.

Thirdly, as Arne Jemstedt described in his paper, the dual aims of psychoanalytic training are healing and scientific traditions. In the aspect of scientific tradition, examples are research in neuropsychoanalysis, like the Nobel winner Eric Kandel does, theoretical teaching in universities, and interdisciplinary thinking to work on the interphase of psychoanalysis and literature, philosophy, art etc. These are new directions where psychiatrists could play a role of synthesis and integration.

Psychiatrists with psychoanalytic training background play an important role in teaching, too. Among the nine analysts in Taiwan Center, there are four psychiatrists. Although only one of them is still in psychiatric clinical practice, all of them do supervision with psychiatric residents either in group or individually. Similarly, there are a total of 18 candidates in Taiwan. Five of us are psychiatrists. We are still in full-time or part-time psychiatric practice, and doing lectures or clinical supervisions for young generations in residency training.

Before the pandemic of COVID-19, Taiwan Center, the IPA recognized allied center of Taiwan, has a long history of inviting European and American analysts to do short-term visits. They would also give lectures to psychiatrists. Dr. Jorge Canestri visited Taiwan in 2014, and gave a speech in the Annual Congress of Taiwan Society of Psychiatry. With his extensive experiences of working as director of psychiatric ward and psychiatric residency training, Dr. Rudi Vermote visited Taiwan several times and talked in different settings about psychoanalysis and psychiatry. The lists of “guru” psychoanalysts included David Bell, Stefano Bolognini, Mary Target, and Salman Akhtar. Young psychiatrists are used to having psychoanalysts, together with experts in psychopharmacology or molecular psychiatry, giving lectures in conferences. In this way, although the psychotherapeutic training is not limited to any particular school, psychoanalysis has in fact occupied an important place in the training program. This is probably also due to a new trend of clinical practice. Local psychiatric clinics has become a popular form of practice as seeing psychiatrists are no longer regarded as something shameful in Taiwanese society.

Of course, psychoanalytic training does not always bring positive impact on the training and practice to psychiatry. The first challenge is the differences of diagnostic system and terminology. Not only because many classical psychoanalytic articles were written in different era, when ICD and DSM systems were in older editions; but also, we see that similar phrases are stretched to cover different concepts in psychoanalysis than in psychiatry. Young psychiatric residents often get confused and lost when reading psychiatric and psychoanalytic writings at the same time. Secondly, for young generation psychiatrists, medical training is more about protocols, manuals, and problem-solving. On the contrary, even with some basic rules, dynamic psychotherapy is always in a dialectical way of thinking and reflection. New therapists need to have greater tolerance in face of the anxiety of "not knowing". It also means challenge on medical doctors' feeling of omnipotence. Supervision is important but not yet a well-established training program.

Finally, being a psychiatrist can mean differently to each of us. Besides from securing a basic knowledge and ability in the training process, I think it is the choice of each individual psychiatrist to develop his/her further subspeciality. Psychoanalytic training or dynamic psychotherapy can be a direction of career choice, if not a basic requirement for all psychiatric residents. I would like to end my speech by saying that I have found a comfortable professional place, in which I do things that I like, while feeling that I can contribute to my professional field and my patients. And I hope each of the audience here would be able to find yours. Thank you very much for your attention.

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International Panel Discussion: The impact of psychoanalytic training on psychiatric practice and identity of a psychiatrist
Discussion

Discussion to the three papers

Yuri Seino

Training Institute of the Japan Psychoanalytic Society

First of all, I would like to express my gratitude to Dr. Behmann, Dr. Bomba, and Dr. Yu for their wonderful, precise and thought -provoking presentations. I am also a psychiatrist training in psychoanalysis, so it is my pleasure to have the opportunity to join this panel and discuss their papers. I am also grateful to Dr. Okamura and Dr. Eto, for having me as a discussant.

First, I start from responding to Dr. Behrmann's presentation.

Dr. Behrmann talked about the benefits of acquiring psychoanalytic perspectives in a very convincing way. In particular, he showed us the importance of recognizing unconscious motivations, transference, or resistance behind the limited effectiveness of medication. In addition, his emphasis on assessing patients' functions in terms of personality brings deep and multiple perspectives to our daily psychiatric practice.

Now I would like to focus on the training. His approach to his patients seems quite flexible and I believe that it is based on his deep psychoanalytic understanding. However, as he pointed out, most psychiatrists do not have full psychoanalytic training because it takes too much time and money. Therefore, to me, the "one to two-year psychoanalytic psychotherapy program" that he mentioned seems quite helpful for a lot of psychiatrists to acquire some basic psychoanalytic understanding. So, I would like him to tell us more about the program. Does it include having training cases with supervision and personal psychotherapy, or is it mainly theoretical? Personally, I think it is inadequate to learn only analytic theories, because it may lead clinicians to use analytic concepts mainly for their own defenses, not for understanding patients' suffering. It seems crucial to me to experience during training truly emotional interactions with patients or their own therapists. I would also like to know his opinion on this point.

And lastly, I would like to refer to the two examples that he raised. It is moving that his persistent care and effort with Stacy finally brought her to residential treatment. He also presented Bill's case as a failure. It is always really difficult to assess patients' resistance

Yuri Seino, M.D.
Training Institute of the Japan Psychoanalytic Society
SC Building 6th Floor, 3-4 Yotsuya , Shinjuku-ku, Tokyo 160-0004, Japan
e-mail: yuriseino24@gmail.com

or motivation accurately. However, I feel that we can also see the case from a different perspective. In my view, it may not be a failed case but rather it seemed inevitable that Bill would leave the treatment, as perhaps he unconsciously repeated his traumatic event of the separation from his father. I imagine that for him, Dr. Behrmann was his father, and his fiancé was his mother as Dr. Behrmann described. So he (and his mother/ fiancé) had to experience a painful separation from his father/ Dr. Behrmann. Of course the therapist must have played a certain role. Perhaps Bill himself took the role of his father and abandoned Dr. Behrmann and the therapist. We can imagine several stories in his internal world.

Clinical cases always teach us a lot, and that is one of the reasons why I believe that learning only theory is inadequate. I appreciate that Dr. Behrmann gave us a wonderful opportunity for reflection through his cases.

Now I move on to my comments on the presentation by Dr. Bomba.

Dr. Bomba showed a beautiful pairing of psychoanalysis and psychiatry through Rosa's case. What was amazing to me is that I felt as if I had been reading a description of a dramatic session of a psychoanalytic case although it was Dr. Bomba's first contact with Rosa, and not their analytic session itself, that she described. It is probably because her psychiatric practice is based on, or rather weaved with, psychoanalytic attitude.

Furthermore, Dr.Bomba showed us the importance of a "space in between", referring to her professor's words and a gesture. I imagine that she understood them as a space not only between psychoanalysis and psychiatry, but also between fragmentation and integration, deadness and aliveness, psych and soma and so on and so forth. To me, it seems that the in-between space is where the infinite (the wildest thoughts) begins to have some form/ the finite (voice).

Now I would like to mention more about Rosa's revival. When Rosa, who "is a cadaver", becomes furious and violent, Dr. Bomba sensitively sees a scared little child. She also finds the subtle change of her muscle tone. Her sensitivity, her holding, the containing by the ward, and also her colleague's care about Rosa, all these things seem to me to be important factors for Rosa to "be born", as it were.

Here, I would like to ask Dr. Bomba about Rosa's caesura/ birth. I think she emphasizes the patient's drastic change between "before" and "after" caesura. Indeed, it is really moving to see how she dramatically revived from "a cadaver". However, I would like to focus on the continuity, what is invariant before and after caesura, rather than the change or discontinuity. I have the impression that Rosa was desperate to live, survive, even before the caesura, because she tried to warm herself with "a hovel of blankets and sweaters" and a hot water bottle which she put so tightly to her abdomen that she got some trace there. She seemed to try to be alive despite fear of dying in the dark room/ the womb. However weak it might be, her aliveness was consistent over the caesura, and it seems to me that this aliveness finally found "voice" when Dr. Bomba's colleague opened the door with "all that light", and also when Dr. Bomba saw a scared child in Rosa and held her.

This is the way I view this impressive case, and I would like to know what Dr. Bomba thinks about my understanding.

Thank you so much again for such a moving presentation.

And finally, I would like to express my gratitude to Dr. Yu for her detailed explanation of the training system in Taiwan and for sharing her personal experience so honestly.

She also beautifully described three levels of contributions by psychoanalysis or psychoanalytic training to the psychiatric field.

First, she pointed out the usefulness of the psychoanalytic understanding of a doctor-patient relationship in our daily psychiatric practice, especially in terms of transferential enactment by patients. She also explained the mechanism of idealization and the subsequent disappointment in doctors by patients. I totally agree with her that these analytic understandings help us in our daily practice in a hospital.

Secondly, she focused on the better collaboration between treatment team members through a psychoanalytic perspective.

And thirdly, she mentioned the integration of psychoanalysis and other scientific or academic fields such as neurology, literature, philosophy and art.

Personally, I am really glad to hear her presentation because I have almost the same feelings as hers about what she has shared with us, such as her initial feeling of being marginal, or her determination of maintaining the psychiatric practice along with psychoanalytic training. I believe that her honest description gives courage and hope to those who are interested in, but still hesitant about, learning psychoanalysis.

Here, however, I dare to ask her about a possible negative effect on our daily psychiatric practice when we learn psychoanalysis, because I believe people should know both sides of things.

When I started learning psychoanalysis, I sometimes wanted to give interpretations in a ten-minute consultation, or, hesitated to give supportive words when necessary. These are because I ignored the setting and used analytic techniques in a wrong way, and they often ended up undermining the relationship with my patients.

They are just examples, but we may say that in the course of our analytic training, acquiring analytic perspective can bring us some confusion and failure in our psychiatric practice.

So here, I would like to ask Dr. Yu about the following question: Do you have any similar experience, in which you failed to function effectively in your daily psychiatric practice just because you also have psychoanalytic thinking?

And if so, I would also like Dr. Yu to tell us about it and about her present thoughts on it.

Finally, I would like to add one more thing. I appreciate Dr. Yu's mentioning the history of colonization by Japan. Although we do not have time to discuss this topic closely here, she gave us an important opportunity to reflect on ourselves who colonized other countries. I am grateful to Dr. Yu for reminding us of this important history.

Finally, again, I would like to express my gratitude to Dr. Behrmann, Dr. Bomba, and Dr. Yu for their wonderful presentations, and I believe this panel will encourage the audience to have more interest in psychoanalysis.

International Panel Discussion: The impact of psychoanalytic training on psychiatric practice and identity of a psychiatrist
Discussion

Replies to the discussion

Joe Behrmann

First, I would like to talk about programs for one or two years of training in psychoanalytic psychotherapy. Many organizations in the US have such programs. I believe that both physicians and psychologists are familiar with them. Psychiatric residencies include a few psychotherapy programs, and some courses are sponsored by universities. However, an increasing number of psychoanalytic institutes and centers are now sponsoring such programs, rather than universities or medical training programs. The programs vary in content; classroom theory is the foundation, followed by, or in parallel with, actual clinical experience and supervision. On a short-term basis, supervision may be group supervision. Many places have online courses because of COVID-19, and a number of them can be found just by searching online. For example, the website of the American Psychoanalytic Association (APsaA) has courses on psychoanalytic psychotherapy offered by some of the groups that belong to it, with links to their websites. I have also been involved in psychoanalytic psychotherapy myself, and have found it to be a very effective method. I started with a course in psychoanalytic psychotherapy, and would heartily recommend it as post-graduate training in terms of its usefulness in actual medical practice.

In Bill's case, when he brought his fiancée to the clinic, he was like a small child with his mother. Therefore, it makes a lot of sense that this place is a re-creation for him of the place where he is with his parents. I also understand that he left, not because I made a terrible mistake, but because it was inevitable. Nevertheless, I still believe that my understanding of the case was not good enough. I think I would make a different decision now, and I have. Compared with that period, my psychoanalytic training has helped me understand my patients to a greater degree. Maybe I was more inclined then to recommend what I thought was good, and I was not as good at understanding the patient as a whole as I am now. In Stacey's case, I was surprised that she came back. I honestly thought that would be the end of it. I think the experience with the patient is what brings the most out of it, and it was a very memorable experience.

Monica Bomba

Thank you for such inspiring comments. I start with the last one, the one about the caesura "between a before and an after", and then get to the first one about Prof. B's teaching of being able to stand in the space *in between*.

I think it is necessary to emphasize that the caesura/birth was not a "real" experience,

but a *reverie*. I will focus only on the encounter between Rosa and me (and not on what happened earlier with the other colleague). I consider the first reverie of Rosa—small and frightened child—that appeared in my mind as I approached her in the ward, as one first unconscious communication occurring in the field that was beginning to develop between the patient and myself. I always consider the occurrence of a reverie as the signal of a communicative (unconscious) intention within the couple, so the perception of a meeting between two individualities and the formation of a relational field. In fact, if this unconscious communication happens, then there might also be a relationship and a desire/hope for life.

Just as the reception of this first reverie was foundational to the relationship with the patient, so the caesura of birth (when I held the patient in my arms) represents, in my view, also a reverie pre-conceived by the patient while she was with me: a co-built pre-conception that I was able to think at as a shared affective truth. So, it is not a question of whether there was a life intention even before this moment (which certainly existed), in my view, but how much this birth-reverie was necessary to create a space, in between, to begin to feel that we were two (what Bion calls *two-ness*) and thus begin to create a mind to think thoughts, where there was a paralyzing split between mind and body.

This, I believe, was Prof. B's teaching: to use splitting constructively, and not destructively and paralyzingly; to listen to divergent, or seemingly conflicting, ideas, tensioning them within oneself to create a space in which wild thoughts (like that of 15-year-old Rosa finally being born) can take shape, feed the mind and free hope and desire to live.

Nancy Pei-ling Yu

I want to show my appreciation for Dr. Yuri Seino's discussion and the chance to exchange experiences. Here are my thoughts on your response.

It is not an easy job to shift back and forth in the theoretical frame and clinical practice of psychiatry and psychoanalysis, especially for beginners. The confusion between "psychoanalytic-oriented understanding" and "psychoanalytic practice" often, as Dr. Seino pointed out, caused some unfavorable response from our patients. For me, an attempt to give interpretations and to expect immediate impacts on patients seems to relate more to my omnipotent illusion than a good clinical judgement. After quite a lot of experiences of failure, I later learned that it was not the "content" of my interpretation that mattered, but my interpretation "in" the transference did impact on patients. When patients seek help, psychiatrists face challenges in several different levels. If I may say so, patients' expectation of gratification comes before their motivation to see the truth (here I quote Bion's idea that human being come with a motivation of seeking truth), which is perfectly understandable. When people suffer, the removal of their pain is in priority. Our challenge would be to titrate the dosage of frustration to patients. With psychoanalytical understanding, we see symptoms and problematic object-relations in different ways. The technique to convey my understanding to patients and their family, or the choice of treatment strategies, becomes lessons to learn.

Last but not least, I would like to address the issue of Japanese colonization. Just like the universal ambivalent feelings towards our parents, I think the colonization causes

similar ambivalent feelings to Taiwanese, too. An all-good or all-bad tendency of viewing this historical fact would be related to primitive defense mechanisms of slitting and projection. Nowadays, the connection and feelings of nostalgia towards Japanese remains strong in Taiwanese society. I guess this feeling can easily be seen in my article, too.

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International Panel Discussion: The impact of psychoanalytic training on psychiatric practice and identity of a psychiatrist

Overview of the symposium in the 118th annual meeting of the Japan Society of Psychiatry and Neurology (JSPN)

Nobuaki Eto

Institute of the Japan Psychoanalytic Society

The Japan Society of Psychiatry and Neurology is the largest and main academic society of psychiatrists in Japan. About 20,000 members belong to this society. Under the influence of COVID-19 pandemic, the 116th (2020) annual meeting of the society was held only through online, and the 117th (2021) was held in Kyoto but under the limit of a declaration of a state of emergency of pandemic.

This 118th (2022) annual meeting of JSPN was held at the Fukuoka International Congress Center in Fukuoka-City, between 16th to 18th of June. People could gather on site without strict restrictions for the first time in three years. This time we could also use live online distribution systems, and on demand streaming services afterwards.

As members of Japan psychoanalytic study organization, we invited a few members of International Psychoanalytic Studies Organization (IPSO) to this symposium 118th JSPN.

Monica Bomba from Milan, Italy, Joe Berman from St Louis, USA and Nancy Pei-Ling Yu from Taipei, Taiwan willingly accepted our proposal. From October 2021, we launched our project team and started to discuss our subject. The theme of symposium was “The impact of psychoanalytic training on psychiatric practice and identity of a psychiatrist”. Fortunately, the program committee of 118th JSPN accepted our proposal of our symposium in December 2021. In Japan, many psychiatrists know a little about psychoanalysis and some of them are interested in it. The subject of this symposium was intended to have psychiatrists in Japan interested in psychoanalysis.

Over 2,000 people attended the 118 JSPN on site. Our symposium was held on the last day. (June 18th, Sat, 1:30–3:30 p.m.)

Dr. Okamura and I were chairs of the session. Dr. Okamura introduced the members of this symposium. Dr. Bomba, Dr. Berman and Dr. Yu presented their papers.

Three presenters discussed about their treatments of the patients whom they came across as a psychiatrist and they shared their experiences as being psychiatrists and psychoanalytic trainees.

Their practices were mainly based in the field of psychiatry. They approached those

Nobuaki Eto
Institute of the Japan Psychoanalytic Society
SC Building 6th Floor, 3-4 Yotsuya , Shinjuku-ku, Tokyo 160-0004, Japan
e-mail: etonobu@me.com

patients psycho-dynamically/psychoanalytically. The subjects they mentioned in this symposium were about therapeutic team, psychoanalytic assessment, patient-therapist relationships, such as transference and enactment in psychiatric settings. They also discussed about the training.

Dr. Seino gave comments on their presentations and asked three presenters questions, and the presenters replied to those questions. Then all discussants exchanged opinions mainly on the psychoanalytic training as a psychiatrist and how we tried to establish our identity of a psychiatrist and a psychoanalyst at the same time. We could understand that not only in Japan, but also in foreign countries, psychiatrists who train to become psychoanalysts are rare and the training is very tough for every candidate, even though the psychoanalytic thought and practice are more popular among psychiatric trainees in foreign countries.

A participant in the venue, who was interested in psychoanalysis and becoming a psychoanalyst, asked those three presenters, how they managed their lives and professional trainings.

There were about 20 participants in the venue and 24 participants through the internet. After the session, there were 175 on demand viewers. I suppose this session would make all the participants interested in psychoanalysis.

I would like to mention the significance of this symposium. It was the only session spoken in English other than the events of the international committee of JSPN. We could discuss each other lively o time through internet. We also could introduce psychoanalytic training, experiences as trainees and our culture to psychiatrists in Japan. I suppose this was the first challenge that IPSO was involved in psychiatric field in Asia.

This 118th annual meeting of JSPN was considered as a memorial event to mourn Professor Masahisa Nishizono. He passed away on 19th of April, just before this meeting. He was the first professor of Department of Psychiatry, Faculty of Medicine, Fukuoka University. He pioneered psychoanalysis in Japan's domestic psychiatric field, and he had led psychoanalysis and psychodynamic psychiatry in Japan for more than six decades. He had made Fukuoka one of the centers of psychoanalysis in Japan, in which many psychoanalysts and psychoanalytic therapists were produced.

Professor Nishizono would have had the special lecture, titled "The Skin-Ego and the Muscular-Ego in psychiatric field". Unfortunately, we could not listen his lecture. Instead of his lecture, there was a memorial symposium on the same day. I was very happy and honored to introduce IPSO and training of psychoanalysis to Japanese psychiatrists from Fukuoka.

Lastly, we want to express our gratitude for those who were attending this symposium and all those who collaborated with us. Especially, our foreign colleagues, Dr. Bomba, Dr. Berman and Dr. Yu.

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Personal Opinions

My personal view: What psychoanalysis means to JPS psychoanalysts in modern-day Japan

Kunihiro Matsuki

Former President, The Japan Psychoanalytic Society

Private practice and Chihaya ACT Clinic

Abstract: In this paper, first I briefly introduce the history of JPS, the composition of the JPS members and candidates, and the diversities of their schools and traditions of psychoanalysis including psychoanalysis which are unique to Japan.

Most Japanese psychoanalysts have used psychiatric medical facilities as its major field of activities. But, in recent years, a growing number of members and candidates have been practicing clinical psychoanalysis at their personal offices.

As a result, the aims of psychoanalysis have also been changing, from improving and alleviating the psychiatric symptoms that a patient suffers, to transforming the personality and the mind of the patient himself.

The psychoanalyst's aim is to make the patient's personality enhance its ability to tolerate the psychic pain that he has experienced thus far, and which he will likely experience in his future life. I personally think that analysts in my country are tackling clinical psychoanalysis along this line.

However, the establishment of goals and subjects of psychoanalysis such as these does not mean that we are disregarding the application of psychoanalysis. There also are analysts who practice dynamic psychiatry and group therapy, and analysts who work in the welfare sector.

Key words: modern day Japan, psychoanalysts in Japan, aims of psychoanalysis, psychic pain.

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Kunihiro Matsuki

Former President, The Japan Psychoanalytic Society

Private practice and Chihaya ACT Clinic

1-2-2 Hakata-ekiHigashi, Hakata-Ku, Fukuoka City 812-0013

e-mail: matsutre@gmail.com

First I briefly want to describe the history of the Japan Psychoanalytic Society (JPS). Japan's psychoanalytic society, to which Freud granted his authorization, was established in 1931 as the IPA Tokyo Chapter by Yasokichi Yabe and later, additionally, as the Sendai Chapter by Professor Kiyoyasu Marui, a psychiatrist. Later, after Japan's restoration in the wake of the Second World War, the chapters were integrated by psychiatrist Heisaku Kosawa, and the current JPS came into being in 1955. (Kitayama, O. 2010, Nishi, M. 2019)

For a while after this, psychoanalysis was studied and practiced mainly by psychiatrists in the area of psychiatric medicine. Because of this, making dynamic psychiatry widespread and practicing psychotherapy within the scope of psychiatric treatment–became the mainstream, and, as a result, the JPS, which is an organization of psychoanalysts, continued to carry out only modest activities.

From the 1980s, however, exchanges with the Menninger Clinic in the US and overseas training began to be actively pursued. In addition, by undergoing inspections by, and receiving advice from the IPA concerning the training of psychoanalysts, the JPS began working, in the mid-1990s, to reestablish a system of training that complies with the IPA training standards. Today, we are engaged in training candidates and carrying out activities and research in ways that conform to these IPA standards. (Matsuki, K. 2013)

Currently, the JPS is comprised of 45 members and more than 20 candidates, with one institute and two branches engaged in education and training. During the past few years, two to five new individuals have become members, and two to three new candidates have joined our organization. Many of the members and candidates are psychiatrists. A recent trend is the increase in members who are clinical psychologists by profession. On the other hand, there are no social workers, nurses, or people of other disciplines. This is because the current rules for applying as a candidate were created with physicians and clinical psychologists in mind. I believe that these will eventually need to be revised.

Many of our current members and candidates work in the field of clinical psychiatry. Some of them are involved with the education and research of doctors and clinical psychologists in universities and graduate schools.

What do these occupational states show about psychoanalysis within the JPS? To show them to you, I have so far described what work the JPS constituent members basically do, and what their forms of work is like.

The school and tradition of psychoanalysis on which the JPS members and candidates rely are diverse. Freud's psychoanalysis is, of course, respected. At the same time, we can mainly see the influence of psychoanalysis originating in the US and the UK, which subsequently grew and developed. The flow of ideas from the US such as ego psychology, self-psychology and relational psychoanalysis coexists with the flow from the UK that includes object relations theory, contemporary Kleinian theory, and the Bion tradition.

There are also analysts who are using these as the basis to create psychoanalysis that is unique to Japan. Examples may include the late Dr. Takeo Doi's Amae theory; the late Kosawa and Okonogi's Ajase Complex, and Dr. Osamu Kitayama's Prohibition of the Don't Look theory. I, too, have discovered the relationship between India's cultural thinking and Japan's Zen Buddhism as the matrix of the late Bion's psychoanalysis, and am currently investigating psychoanalytic experiences by keeping in mind *Mushin*, or

"no-mind" from Zen Buddhism as the key concept. (Doi, T. 2004, Kosawa, H. 1931/2022, Okonogi, K. 2004/2022, Kitayama, O. 2010, Matsuki, K. 2021.)

As I have stated earlier, Japanese psychoanalysis has used psychiatric medical facilities as its major field of activities. In recent years, however, a growing number of members and candidates have been practicing clinical psychoanalysis at their personal offices. In other words, the practice has expanded, from offering psychoanalysis and psychotherapy at medical institutions, to providing traditional individual psychoanalytic therapy of the type that has continued since the days of Freud.

As a result, the aims of psychoanalysis have also been changing, from improving and alleviating the psychiatric symptoms that a patient suffers, to transforming the personality and the mind of the patient himself. The model of personality and the mind, the theory concerning its pathology, and the methods and approaches used in this practice for attaining the goal of psychoanalysis, which is transformation of the personality and the mind, vary according to the school and tradition on which the analysts rely. However, transformation is the goal of analysis. What sort of transformation, then, is the 'transformation of the personality and the mind'?

At the way I see it, it is a 'return to Freud.' Freud wrote the following in the last paragraph of the final chapter, "Psychotherapy of hysteria" in "Studies on Hysteria" which he wrote in 1895.
I quote:

> "When I have promised my patients help or improvement by means of a cathartic treatment I have often been faced by this objection: 'Why, you tell me yourself that my illness is probably connected with my circumstances and the events of my life. You cannot alter these in any way. How do you propose to help me then?' And I have been able to make this reply: 'No doubt fate would find it easier than I do to relieve you of your illness. But you will be able to convince yourself that much will be gained if we succeed in transforming your hysterical misery into common unhappiness. With a mental life that has been restored to health you will be better armed against that unhappiness.'". (Freud, S. 1895. SE. 2, p. 305)

Here, Freud does not tell the patient that he will heal her, or improve her symptoms, or make her happy. What he is saying instead is that he will change her hysterical misery into common unhappiness. He says that, with a mental life that has been restored, the patient will be able to better deal with that common unhappiness by herself.

To paraphrase this using meta-psychological terms, it would be something like the following: Rather than making service to the primary process of psychic functioning that complies with the pleasure-pain principle of eliminating pain, which is what is expected of general medicine, we are reinforcing the secondary process that complies with the reality principle. In other words, instead of actively eliminating unhappiness and offering happiness, we help the individual build a mind that can tolerate the unhappiness that he or she is feeling in his or her life.

Wilfred Bion describes this work of psychoanalysis more directly. I quote:

> "The assessment ("that is 'improvement', the writer adds") itself has not significance for psychoanalysis, in the sense that "cure" and "improvement" have a significance in the domain of physical medicine". (Bion, W. 1967, p. 155)

> "Successful analysis does lead to diminution of suffering; nevertheless it obscures the need…for the analytic experience to increase the patient's capacity for suffering even though patient and analyst may hope to decrease pain itself." (Bion, W. 1963. p. 62)

Psychoanalysis aims to make the patient's personality enhance its ability to tolerate the psychic pain that he has experienced thus far, and which he will likely experience in his future life. This is about developing the ability to maintain 'negative capability' (Bion, W., 1967. pp.19–28), which allows the patient to face his psychic pain as psychic pain, and to think about it. I personally think that analysts in my country are tackling clinical psychoanalysis along this line.

This recognition is the basis of the practice of psychoanalysis in contemporary Japan. It is the matrix. As a result, the subjects of analysis are no longer limited to patients with mental illness, but have been expanded to include individuals who require analysis to fulfill their life in ways they themselves can agree with, as well as individuals who find analysis useful for this purpose.

However, the establishment of goals and subjects of psychoanalysis such as these does not mean that we are disregarding the application of psychoanalysis.

In fact, although the form of private practice has been increasing among psychoanalysts in Japan, the number of those who operate private practice full-time remains still not so much. Many are working in the field of psychiatry and education, in addition to carrying out private practice on a part-time basis. There also are analysts who practice dynamic psychiatry and group therapy, and analysts who work in the welfare sector.

Some people might say that we should broaden our range even further and step into the field of applied psychoanalysis or take on more outreach-type activities. The fact, however, is that analysis in Japan today continues to focus on involving the individual's mind, and understanding the person and the mind that derive from it. I suppose that these efforts will continue into the future.

Some of you here, who had perhaps expected to hear more in-depth views and opinions about how Japan's analysts regard psychoanalysis, may be disheartened by my presentation today. However, I personally believe that the answer to the question of what psychoanalysis is, is something that each psychoanalyst discovers within the context of his or her own clinical practice. This is why I have decided to merely introduce today the foundation from which the members of JPS will likely produce their answers.

Lastly, let me tell what Bion said when asked the question, that is, "Is psychoanalysis a depth phenomenology?"

I quote it here, and it concludes my presentation.

> "There is a lot to be said for a phrase which was used by Melanie Klein to me: "Psycho-Analysis is a meaningless term, but it is available." It is a word in search

of a meaning; a thought waiting for a thinker; a concept waiting for a content." (Bion, W., 1978. p. 59)

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The ideals and editorial policies of *The Journal of the Japan Psychoanalytic Society*: Principles, editorial policies, and manuscript submission guidelines (Prepared and approved on April 12, 2018. Revised and approved on February 18, 2019)

Basic principles

1. *The Journal of the Japan Psychoanalytic Society* offers a forum for individuals linked to the Japan Psychoanalytic Society (JPS) to publish information on their clinical practice of psychoanalysis and academic studies based on it. English is the language used.
2. As the bulletin of our Society that informs on Japanese developments, the *Journal* aims to be a forum by which to release, globally, information on clinical practice and research being carried out in Japan, and to conduct international exchanges.
3. As an academic journal for psychoanalysis, it aims to present an abundance of highly sophisticated content.

Editorial policies

1. An Editorial Committee will be organized. Members of the Committee, chiefly the Chairperson and Vice Chairpersons, will be responsible for the editing work. They will ask overseas IPA Members for their assistance in serving as Visiting Editorial Committee Members.
2. Eligible to submit manuscripts are members of the Japan Psychoanalytic Society and other suitable individuals; members of other countries' psychoanalytic societies and who are approved by members of the Editorial Committee as being eligible; and individuals within other institutions whose papers and articles are approved by the members of the Editorial Committee as worthy of being featured in the *Journal*.
3. Language used: Papers and manuscripts are to be submitted in English. Japanese language editions may also be inserted if the authors so request, and with the Editorial Committee's approval. When contributing a paper, authors are advised to attach, where possible, a Japanese translation.
4. Publication will be in an e-journal (electronic edition) format. The *Journal* will be distributed only to JPS Members and related individuals, to overseas psychoanalytic societies, and psychoanalytic institutes.
5. The content will consist of two types of manuscript: reviewed and not reviewed. The details will be outlined in the Manuscript Submission Guidelines.
6. The *Journal* will feature papers related to the acquisition of qualification as a JPS-certified psychoanalyst and psychoanalytic psychotherapist.
7. Because the *Journal* uses English as its official language, it will be a separate entity from the *Annual Report*, which is published in Japanese.
8. The *Journal* is planned to be published once a year, prior to the Society's Annual Meeting held in June.

Manuscript submission guidelines

1. Manuscript format: Papers should be about 5,500 words in total, including references and charts that have been kept to a minimum. The total should, in principle, not exceed

8,000 words. All material must be produced in MS Word form and sent as an email attachment. Essays and reports must not exceed 4,000 words in total; and letters and book reviews, no more than 2,000 words in total. These numbers include all the content, not only the body text but also the title, affiliation, references, acknowledgments, etc.

2. Criteria for acceptance or non-acceptance: To be decided by the Editorial Committee.
   The paper must not have been already published in English: papers that have already been inserted in other English journals will not be considered for review.
   In conducting our investigations, three members of the Editorial Committee, selected to look at each paper, will review the manuscripts. The opinions of non-Japanese analysts, who are Visiting Editorial Committee Members, may also be obtained as necessary. The Editorial Committee will then study each paper, based on the comments made during the review.
   The date on which a paper has been submitted will be designated the Date of Receipt, and the date on which inclusion in the *Journal* has been decided will be designated the Date of Acceptance.
3. The paper/report must comply with accepted ethical codes that govern scientific research. The authors will be responsible for meeting confidentiality obligations.
4. The themes and categories of manuscripts acceptable for submission are as follows.
   Theories and Techniques, Clinical Communications, Child Psychoanalysis, History, Interdisciplinary Studies, Psychotherapy, Educational and Professional Issues, Essays, Letters to the Editor, Obituaries, and Book and Journal Reviews. These themes and categories may be revised and/or enlarged.
   Authors submitting their research papers are asked to submit an original paper, as a basic rule, which will then be reviewed. However, direct insertion of invited lectures or presentations given at international conferences, etc., may be approved, based on examination by the Editorial Committee. Educational and professional issues, essays, letters, book reviews and the like will be proofread by the Editorial Committee.
5. The submitted paper should be constructed as follows.
   The author must clearly write, above the title of the paper, the category in which he or she requests the paper to be published.
   Next should follow the title (if needed, a subtitle may be added), name, affiliation, postal address and email address; then the key words (up to 5 words), abstract (up to 600 words), body text, and references. The IPA *Journal*'s writing style should be followed when writing the references.
6. Diagrams should be clear and inserted in the correct position in the text. The diagrams' original image file and source data (in Word, Excel, or PowerPoint form) should be sent separately.
7. The author should proofread the manuscript for the first proof only.
8. The Japan Psychoanalytic Society reserves all rights. No part of this journal may be reprinted, reproduced, utilized for imports into our Internet database accessible by JPS Members, or distributed, without permission in writing from the JPS.
9. The paper must be sent to The Japan Psychoanalytic Society's e-mail address: tokyo@jpas.jp

The Japan Psychoanalytic Society
4 Yotsuya 3-Chome, Shinjyuku-Ku, Tokyo 160-0004, JAPAN
E-mail address: tokyo@jpas.jp
Fax: +81 33 3263 8693
Homepage: www.jpas.jp/ja/ (Japanese). www.jpas.jp/en/ (English)